

4734

## CERTIFICATE OF DEATH

64624

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Mont.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>Arms</u> Last <u>Leder</u>				4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 6, 1892</u>	
9. AGE (In years lost birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		11. BIRTHPLACE (State or foreign country) <u>Cincinnati, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Arms Leder</u>				14. MOTHER'S MAIDEN NAME <u>Gerena Hadenstein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>		INFORMANT Address <u>Margaret Arms Leder (wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>203X</u> DUE TO <u>GASTRIC HE MORRHAGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>multiple</u> DUE TO <u>MYELOMA</u> (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>30 HRS.</u> <u>10 MONTHS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>April</u> Day <u>8</u> Year <u>1960</u> Hour o. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Bethesda, Maryland</u>				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 8, 1960</u> to <u>April 9, 1960</u> , that I last saw the deceased alive on <u>April 9, 1960</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert N. Coale</u>				ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave Bethesda, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>				DATE SIGNED <u>4/9/60</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 12 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

203X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reave carban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
M  
073  
1

1  
M  
073  
1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4735  
CERTIFICATE OF DEATH

64625

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>21 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b> d. STREET ADDRESS <b>DOUGHOREGAN MANOR</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>LUCY -- ASBURY</b>				4. DATE OF DEATH Month Day Year <b>APRIL 16 1960</b>							
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/25/90</b>		9. AGE (In years lost birthday) yrs. <b>69</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>DUTTON GRIFFITH</b>				14. MOTHER'S MAIDEN NAME <b>NANCY WHITEHEAD</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NINE</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>				Address <b>OLNEY, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> <b>196.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Squamous cell carcinoma, right mandible</b> DUE TO (c) <b>1 year</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>CLARKSVILLE</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-24-</b> <b>1959</b> , to <b>4-16-</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>4-16-</b> <b>1960</b> , and that death occurred <b>12:30 A. P.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Christopher, M. D.</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-17-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>C. S. WHITAKER, M. D.</b>						22d. ADDRESS <b>CLARKSVILLE, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>APRIL 18, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WARDS. COVE</b>				23d. LOCATION (City, town, or county) (State) <b>TAZEWELL VIRGINIA</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>						ADDRESS <b>Laytonville Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 20 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

199.



4682

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64626  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 Hrs 5 min</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San + Hosp.</u>				d. STREET ADDRESS <u>9234 Piney Br. Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Roger</u> First <u>Alexander</u> Middle <u>Austin</u> Last				4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-20-33</u>	
9. AGE (In years last birthday) <u>27</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Industrial Engineer</u>		11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Mr Phillip W Austin</u>				14. MOTHER'S MAIDEN NAME <u>Florence A Fleisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>U.S. Army</u>				16. SOCIAL SECURITY NO. <u>507-42-1242</u>		17. INFORMANT Address <u>Mr Phillip Austin</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Abdominal hemorrhage</u> DUE TO (c) <u>Crushed abdomen</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Went down route which left highway &amp; struck tree</u>			
20c. TIME OF INJURY Hour <u>8:30</u> a. m. Month, Day, Year <u>4-14-60</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
				20f. (City or town) <u>Silver Spring Montg</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/18/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Murphy, Inc.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 19 60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1952

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>	
3. AGE <i>45</i>		4. RACE <i>WHITE</i>	
5. DATE OF DEATH <i>10-15-52</i>		6. TIME OF DEATH <i>10:00 AM</i>	
7. PLACE OF DEATH <i>HOME</i>		8. STREET ADDRESS <i>1234 E. BALTIMORE ST.</i>	
9. CITY <i>BALTIMORE</i>		10. COUNTY <i>JOHNS HOPKINS</i>	
11. STATE <i>MARYLAND</i>		12. ZIP CODE <i>21201</i>	
13. OCCUPATION <i>CLERK</i>		14. MARITAL STATUS <i>MARRIED</i>	
15. EDUCATION <i>HIGH SCHOOL</i>		16. RELIGION <i>CATHOLIC</i>	
17. PREVIOUS ILLNESS <i>HEART DISEASE</i>		18. CAUSE OF DEATH <i>MYOCARDIAL INFARCTION</i>	
19. MANNER OF DEATH <i>NATURAL</i>		20. SIGNATURE OF EXAMINER <i>[Signature]</i>	
21. SIGNATURE OF WITNESS <i>[Signature]</i>		22. SIGNATURE OF CORONER <i>[Signature]</i>	
23. SIGNATURE OF JURY <i>[Signature]</i>		24. SIGNATURE OF JUDGE <i>[Signature]</i>	
25. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		26. SIGNATURE OF DEFENSE <i>[Signature]</i>	
27. SIGNATURE OF JURY <i>[Signature]</i>		28. SIGNATURE OF JUDGE <i>[Signature]</i>	
29. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		30. SIGNATURE OF DEFENSE <i>[Signature]</i>	
31. SIGNATURE OF JURY <i>[Signature]</i>		32. SIGNATURE OF JUDGE <i>[Signature]</i>	
33. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		34. SIGNATURE OF DEFENSE <i>[Signature]</i>	
35. SIGNATURE OF JURY <i>[Signature]</i>		36. SIGNATURE OF JUDGE <i>[Signature]</i>	
37. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		38. SIGNATURE OF DEFENSE <i>[Signature]</i>	
39. SIGNATURE OF JURY <i>[Signature]</i>		40. SIGNATURE OF JUDGE <i>[Signature]</i>	
41. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		42. SIGNATURE OF DEFENSE <i>[Signature]</i>	
43. SIGNATURE OF JURY <i>[Signature]</i>		44. SIGNATURE OF JUDGE <i>[Signature]</i>	
45. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		46. SIGNATURE OF DEFENSE <i>[Signature]</i>	
47. SIGNATURE OF JURY <i>[Signature]</i>		48. SIGNATURE OF JUDGE <i>[Signature]</i>	
49. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		50. SIGNATURE OF DEFENSE <i>[Signature]</i>	
51. SIGNATURE OF JURY <i>[Signature]</i>		52. SIGNATURE OF JUDGE <i>[Signature]</i>	
53. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		54. SIGNATURE OF DEFENSE <i>[Signature]</i>	
55. SIGNATURE OF JURY <i>[Signature]</i>		56. SIGNATURE OF JUDGE <i>[Signature]</i>	
57. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		58. SIGNATURE OF DEFENSE <i>[Signature]</i>	
59. SIGNATURE OF JURY <i>[Signature]</i>		60. SIGNATURE OF JUDGE <i>[Signature]</i>	
61. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		62. SIGNATURE OF DEFENSE <i>[Signature]</i>	
63. SIGNATURE OF JURY <i>[Signature]</i>		64. SIGNATURE OF JUDGE <i>[Signature]</i>	
65. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		66. SIGNATURE OF DEFENSE <i>[Signature]</i>	
67. SIGNATURE OF JURY <i>[Signature]</i>		68. SIGNATURE OF JUDGE <i>[Signature]</i>	
69. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		70. SIGNATURE OF DEFENSE <i>[Signature]</i>	
71. SIGNATURE OF JURY <i>[Signature]</i>		72. SIGNATURE OF JUDGE <i>[Signature]</i>	
73. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		74. SIGNATURE OF DEFENSE <i>[Signature]</i>	
75. SIGNATURE OF JURY <i>[Signature]</i>		76. SIGNATURE OF JUDGE <i>[Signature]</i>	
77. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		78. SIGNATURE OF DEFENSE <i>[Signature]</i>	
79. SIGNATURE OF JURY <i>[Signature]</i>		80. SIGNATURE OF JUDGE <i>[Signature]</i>	
81. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		82. SIGNATURE OF DEFENSE <i>[Signature]</i>	
83. SIGNATURE OF JURY <i>[Signature]</i>		84. SIGNATURE OF JUDGE <i>[Signature]</i>	
85. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		86. SIGNATURE OF DEFENSE <i>[Signature]</i>	
87. SIGNATURE OF JURY <i>[Signature]</i>		88. SIGNATURE OF JUDGE <i>[Signature]</i>	
89. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		90. SIGNATURE OF DEFENSE <i>[Signature]</i>	
91. SIGNATURE OF JURY <i>[Signature]</i>		92. SIGNATURE OF JUDGE <i>[Signature]</i>	
93. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		94. SIGNATURE OF DEFENSE <i>[Signature]</i>	
95. SIGNATURE OF JURY <i>[Signature]</i>		96. SIGNATURE OF JUDGE <i>[Signature]</i>	
97. SIGNATURE OF PROSECUTOR <i>[Signature]</i>		98. SIGNATURE OF DEFENSE <i>[Signature]</i>	
99. SIGNATURE OF JURY <i>[Signature]</i>		100. SIGNATURE OF JUDGE <i>[Signature]</i>	

4736

## CERTIFICATE OF DEATH

64627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>5463 Nebraska Ave., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elbert</b> Middle <b>W.</b> Last <b>Baker</b>				4. DATE OF DEATH Month <b>4</b> Day <b>23</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/13/79</b>	
9. AGE (In years lost birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min.		IF UNDER 24 HRS. Months <b>80</b> Days <b>80</b> Hours <b>80</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired (U.S. Agriculture Dept.)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Missouri</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.</b>	
13. FATHER'S NAME <b>Baker, Marion Phelps</b>				14. MOTHER'S MAIDEN NAME <b>Givens, Carry Margaret Givens</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>no</b>		INFORMANT Address <b>Mr. R.H. Baker 754 Cayuga Ave. N.W. Beth.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EXSANGUINATION</b> DUE TO <b>RUPTURE, ANEURYSM OF ABDOMINAL AORTA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS</b> DUE TO <b>ARTERIOSCLEROSIS</b> INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>12 hours</b> <b>UNKNOWN</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 15, 1959</b> to <b>April 23, 1960</b> that I last saw the deceased alive on <b>April 23, 1960</b> , and that death occurred at <b>2:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert B. Havell</b>				DATE SIGNED <b>4-24-60</b>			
PHYSICIAN'S NAME (Type) <b>Robert B. Havell</b>				ADDRESS (Street, city or town, state) <b>5516 Neb. Ave. Wash. D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-26-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Collins</b>				ADDRESS <b>3821-14th ST. N.W. D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
24b. REGISTRAR'S SIGNATURE <b>Chas. L. Hand</b>				DATE <b>APR 26 '60</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Registration

15-20-21

Section

2001 Madison Ave.

Section

John

W.

John

1910

1910

(U.S. Certificate Dept.)

no

CHILD

DEATH

15

DEATH, AMERICAN OR ALIEN

1910

DEATH

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64628

# CERTIFICATE OF DEATH

4683

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover Hills</u> 16X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>9301 Standish Drive</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Ball</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>April 5 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 5, 1960</u>
9. AGE (In years last birthday) yrs. <u>—</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>8</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Richard Carlyle Ball</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jean Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother, 9301 Standish Dr., Lanover Hills, Md.</u>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> <u>7625</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Prematurity (anoxia)</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs. 10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 5</u> , 19 <u>60</u> , to <u>April 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 5</u> , 19 <u>60</u> , and that death occurred at <u>4 p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles R. Hughes</u>		ADDRESS (Street, city or town, state) <u>8226 Fenton St., S.S., Md.</u>	
DATE SIGNED <u>—</u>		DATE SIGNED <u>—</u>	
PHYSICIAN'S NAME (Type) <u>Charles R. Hughes, M.D.</u>		ADDRESS <u>8226 Fenton St., S.S., Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>April 6, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium &amp; Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare, M.D.</u>		ADDRESS <u>Wash. San. &amp; Hospital</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>	
DATE <u>MAY 5 '60</u>		DATE <u>—</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4659

64629

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WHEATON-SILVER SPRING NURSING HOME</b>		d. STREET ADDRESS <b>1313 MASS. AVE., N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>F.</b> Last <b>BARBER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/2/75</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor - Dept. of Agriculture U.S. Govt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Freeport, Illinois</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>	
17. INFORMANT <b>Mr. Harold O. Lovre, 639 Woodward Bldg. Wash. D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerotic Heart Disease - Failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>years 4 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 19 59</b> to <b>April 27 1960</b> , that (I) (we) last saw the deceased alive on <b>April 27 1960</b> , and that death occurred on <b>11:45 A</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas N. Carter</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS N. CARTER</b>		22d. ADDRESS <b>1746 K St N.W Wash DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL 4/29/60</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>FREEPORT, ILLINOIS</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC. Raymond A. Jaska</b>		25a. REC'D BY REGISTRAR <b>MAY 2 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. DATE	



CERTIFICATE OF DEATH

4553

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4737

CERTIFICATE OF DEATH

64630

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>62 days</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>3307 Nichols Ave., S. E.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Kaye</b> Last <b>BARNETT</b>				4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>19 60</b>									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-9-59</b>		9. AGE (In years lost birthday) yrs. <b>5</b> Months <b>26</b> Days <b>26</b> Hours <b>Min.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Douglas BARNETT</b>						14. MOTHER'S MAIDEN NAME <b>Judith GRIMES</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>- - - - -</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>(F) Douglas Barnett, same as #2 above</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>bilateral subdural hematoma</b> 351X DUE TO <b>----</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>----</b> DUE TO <b>----</b> (c) <b>----</b>										INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) <del>personnel</del> attended the deceased from <b>February 2, 1960</b> to <b>April 4, 1960</b> , that (I) <del>see</del> saw the deceased alive on <b>April 4, 1960</b> , and that death occurred at <b>4:45 PM</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>M. W. Wood</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>4-5-60</b>					
22c. PHYSICIAN'S NAME (Type) <b>M. W. WOOD, LCDR, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-7-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				23d. LOCATION (City, town, or county) (State) <b>Arlington Va.</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b> ADDRESS <b>Washington, DC</b>						25a. REC'D BY REGISTRAR <b>DATE APR 7 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>					

2051181XV3

CERTIFICATE OF DEATH

4735

1930

NAME OF DECEASED  
RESIDENCE  
DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH  
MANNER OF DEATH  
AGE  
SEX  
RACE  
RELIGION  
EDUCATION  
OCCUPATION  
MARRIAGE  
SINGLE  
MARRIED  
WIDOWED  
DIVORCED  
REMARKS  
SIGNATURE OF REGISTRAR  
DATE OF REGISTRATION  
OFFICE OF REGISTRATION

1. Name of deceased  
2. Residence  
3. Date of death  
4. Place of death  
5. Cause of death  
6. Manner of death  
7. Age  
8. Sex  
9. Race  
10. Religion  
11. Education  
12. Occupation  
13. Marriage  
14. Single  
15. Married  
16. Widowed  
17. Divorced  
18. Remarks  
19. Signature of Registrar  
20. Date of registration  
21. Office of registration

## CERTIFICATE OF DEATH

Reg. Dist. No.

4631

4684

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>DOA.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>Adelphi</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM W BARNETT</u>				4. DATE OF DEATH Month Day Year <u>4 21 1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/17/80</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Contracting Company</u>			
13. FATHER'S NAME <u>? Unknown</u>				14. MOTHER'S MAIDEN NAME <u>? Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>245-09-4342</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 422.01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Phlebotomies - both legs</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>2 wks.</u> <u>12 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 12</u> 19 <u>60</u> , to <u>4-21</u> 19 <u>60</u> that I last saw the deceased alive on <u>4-20</u> 19 <u>60</u> , and that death occurred at <u>9:35 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.D. Bauer M.D.</u>				ADDRESS (Street, city or town, state) <u>2513 Buck Lodge Rd. Adelphi, Md.</u>			
PHYSICIAN'S NAME (Type) <u>R.D. BAUER, M.D.</u>				DATE SIGNED <u>4-21-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANSIT &amp; BURIAL</u>		<u>4/23/60</u>		<u>CEDAR GROVE CEMETERY</u>		<u>NEW BERN, CRAVEN COUNTY, N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR	
<u>Raymond A. Giska</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
				DATE <u>APR 22 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100-100

Mr. [Name] [Address]  
[City] [State] [Zip]  
[Phone Number]  
[Occupation]  
[Education]  
[Military Service]  
[Political Affiliation]  
[Religious Affiliation]  
[Marital Status]  
[Children]  
[Other Information]

Mr. [Name] [Address]  
[City] [State] [Zip]  
[Phone Number]  
[Occupation]  
[Education]  
[Military Service]  
[Political Affiliation]  
[Religious Affiliation]  
[Marital Status]  
[Children]  
[Other Information]

Mr. [Name] [Address]  
[City] [State] [Zip]  
[Phone Number]  
[Occupation]  
[Education]  
[Military Service]  
[Political Affiliation]  
[Religious Affiliation]  
[Marital Status]  
[Children]  
[Other Information]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

64632

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> <u>4113 Leland Street</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, Md.</u> c. LENGTH OF STAY IN 1b <u>54</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Md. 4113 Leland Street, Chevy Chase,</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase, Md.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Allene</u> Middle <u>Barrett</u> Last <u>Barrett</u>		4. DATE OF DEATH Month <u>April</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-14-1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allen Barrett</u>		14. MOTHER'S MAIDEN NAME <u>Fannie J. Barrett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Joseph W. Thomas</u>		Address <u>Wash. D. C. 4916 Blaine St., N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Arteriosclerosis, general</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 min.</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Parkinsonism Advanced</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>April 30, 1960</u> , that I last saw the deceased alive on <u>April 12, 1960</u> , and that death occurred at <u>8:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u> M.D.		ADDRESS (Street, city or town, state) <u>3921 Ingomar St Washington, D.C.</u> DATE SIGNED <u>4/30/60</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp</u>		<u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-3-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Son Inc, 1756 Pa. Ave. NW. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>MAY 3 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>	







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>C</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN 1b <b>12 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Asbury Methodist Home</b>				d. STREET ADDRESS <b>7701 Georgia Ave., N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lena</b> Middle <b>no middle name</b> Last <b>Barwick</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1875</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>20</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>near Vernon Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Jones Barwick</b>				14. MOTHER'S MAIDEN NAME <b>Susan B. Speues</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Methodist Home Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial occlusion</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <b></b> Day <b>19</b> Year <b></b> Hour <b></b> a. m. <b></b> p. m. <b></b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-3</b> , 19 <b>58</b> , to <b>21</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4-20</b> , 19 <b>60</b> , and that death occurred at <b>9:40 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Sarah E. Glover</b>				M.D. <b>10128 CEDAR LAWE</b>		DATE SIGNED <b>4-21-60</b>	
PHYSICIAN'S NAME (Type) <b>Sarah E. Glover, M. D.</b>				<b>Kensington, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Hillsboro, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balt</b>				24a. REC'D BY REGISTRAR DATE <b>APR 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

# CERTIFICATE OF DEATH

ARKLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

File No.

Monetary

Washington

17 months

Washington, D. C.

The above mentioned

John

to the name

Lawson

Female

White

School Teacher

near Vernon Delaware

U.S.A.

John Jones Lawson

Susan E. Spence

None

James E. Glover, M. D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4738

# CERTIFICATE OF DEATH

04684

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> M		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Burtonsville</b>	
c. LENGTH OF STAY IN 1b <b>Life</b>		d. STREET ADDRESS <b>Santini Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Santini Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bernard</b> Middle <b>Cleveland</b> Last <b>Beall</b>		4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 30, 1883</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Operator-saw mill</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>	
11. BIRTHPLACE (State or foreign country) <b>Burtonsville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Beall</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ella Willcox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Bernard Beall, Burtonsville, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 6</b> , 19 <b>60</b> , to <b>4/15</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 10</b> , 19 <b>60</b> , and that death occurred at <b>8:25 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>402 Main Street, Laurel, Maryland</b> DATE SIGNED <b>4/15/60</b>			
ACTUAL SIGNATURE <b>Robert S. McCeney</b> M.D.		PHYSICIAN'S NAME (Type) <b>Robert S. McCeney, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 18, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Burtonsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Hanna</b>		24a. REC'D BY REGISTRAR DATE <b>APR 19 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

422.

4660

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

64635

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>28 Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1959 SEMINARY ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BESSIE</b> Middle <b>L</b> Last <b>BECKERT</b>		4. DATE OF DEATH Month <b>4</b> Day <b>7</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/16/74</b>
9. AGE (In years lost birthday) <b>85</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas J. Bean</b>		14. MOTHER'S MAIDEN NAME <b>Fannie C. Kidwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>self</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>hemibulbar vascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO <b>2 days</b> (c) <b>Generalized arteriosclerosis</b> DUE TO <b>2 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1949</b> to <b>April 7, 1960</b> that (I) (we) last saw the deceased alive on <b>April 7, 1960</b> , and that death occurred at <b>10:30 M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John S. Rogers M.D.</b>		22b. DATE SIGNED <b>April 7, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>John S. Rogers</b>		22d. ADDRESS <b>1919 Seminary Rd. Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/11/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince George, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>APR 11 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		25c. ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>	

1893

CERTIFICATE OF DEATH

DATE OF DEATH

1893

PLACE OF DEATH

CAUSE OF DEATH

*Handwritten signature and text, likely the name of the deceased and the date of death.*

*Handwritten signature and text, likely the name of the attending physician and the date of the certificate.*

*Handwritten text at the bottom of the page, possibly a footer or additional notes.*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4685 CERTIFICATE OF DEATH

4686

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 10 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 228 PARK AVENUE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK 18 d. STREET ADDRESS 228 PARK AVENUE 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GREER Middle GRIER Last BELL, JR. SAMUEL		4. DATE OF DEATH Month Day Year APRIL 13 1960	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH June 3, 1904
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IRON WORKER		10b. KIND OF BUSINESS OR INDUSTRY Atlas Machine & Iron	
11. BIRTHPLACE (State or foreign country) IRELAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL GRIER BELL, SR.		14. MOTHER'S MAIDEN NAME MARY ELIZABETH BALMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 578-09-0294	
17. INFORMANT Address Mrs. Margaret P. Bell, 228 Park Ave. Takoma Park, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Congestive failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive heart disease DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of the liver	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 6/20 1958 to 4/13 1960, that (I) (we) last saw the deceased alive on 4/4 1960, and that death occurred at 4:10 P.M. from the causes and on the date stated above.	
22a. SIGNATURE Eino Magi M.D.		22b. DATE SIGNED 4/13/60	
22c. PHYSICIAN'S NAME (Type) EINO MAGI		22d. ADDRESS 918 Univ. Blvd. E. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/16/60	
23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WALTER E. RAYMOND PUNTERY INC SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE APR 18 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



443X

1

4739

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

04687

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>45 Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6004 Marquette Terrace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edwin</b> Middle <b>Leonard</b> Last <b>Bingham</b>		4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/17/1897</b>
9. AGE (In years lost birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>29</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home building</b>	11. BIRTHPLACE (State or foreign country) <b>Wyoming</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry DeWitt Bingham</b>	
14. MOTHER'S MAIDEN NAME <b>Agnes Friday</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW 1</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Clara E. Bingham-wife-same 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPHYXIA 20</b> <b>162.1</b> DUE TO <b>Bronchogenic Carcinoma c Metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b> <b>8 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHITIS</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>19</b> Day <b></b> Year <b></b> Hour <b></b> o. m. <b></b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 1, 1960</b> to <b>APRIL 16, 1960</b> , that (I) (we) last saw the deceased alive on <b>APRIL 16, 1960</b> , and that death occurred <b>11:15 P</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b> M.D.		22b. DATE SIGNED <b>4/16/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. J. COSIMANO JR</b>		22d. ADDRESS <b>1835-EYE ST. NW. WASH DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/21/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumfrey</b> ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE APR 19 '60</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

162.1

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>4216-38th St N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Otto</u> Middle <u>J.</u> Last <u>Botsch</u>				4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 4, 1876</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Groceries</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Leonard Botsch</u>				14. MOTHER'S MAIDEN NAME <u>Rosine Shaper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 580x DUE TO <u>Aspiration of Gastric Contents</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Hepatitis</u> (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
19a. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>				19b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
20a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>				20b. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>45</u> to <u>4-18</u> , 19 <u>60</u> that I last saw the deceased alive on <u>4-18</u> , 19 <u>60</u> , and that death occurred at <u>4:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P.P. Andrews</u>				ADDRESS (Street, city or town, state) <u>4201 Resenden St N.W.</u> DATE SIGNED <u>4-18-60</u>			
PHYSICIAN'S NAME (Type) <u>P.P. ANDREWS, M.D.</u>				<u>Washington D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/22/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter W. Lysons Company</u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>APR 21 60</u>			
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

589

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
c. LENGTH OF STAY IN 1b <b>14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. STREET ADDRESS <b>5211 Locust Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie Laura Brown</b>		4. DATE OF DEATH Month Day Year <b>April 11 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/29/79</b>
9. AGE (In years lost birthday) <b>80</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Benjamin F. Broyles</b>		14. MOTHER'S MAIDEN NAME <b>Lucintha</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-44-4120</b>	
17. INFORMANT <b>Mrs. Mark Smith</b>		Address <b>(Same as Above)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>URICEMIA</b> <b>570.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ANURIA</b> (c) <b>Unilateral Obstruction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b> <b>2 1/2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cancer of colon</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/26</b> , 19 <b>60</b> , to <b>4/11</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4/11</b> , 19 <b>60</b> , and that death occurred at <b>5:45</b> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. R. Moses</b>		ADDRESS (Street, city or town, state) <b>1835 Eye SW NW-DC</b>	
PHYSICIAN'S NAME (Type) <b>W. R. Moses</b>		DATE SIGNED <b>4-11-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4/12/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Th S H Harris Co</b>		ADDRESS <b>2901-14 St NW</b>	
24a. REC'D BY REGISTRAR <b>APR 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.



CERTIFICATE OF DEATH

1941

Dec 1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resner Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>3755 Benton St N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>MAGGIE</u> Middle <u>BROWN</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 23</u> 1889
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Newcastle England</u>		12. CITIZEN OF WHAT COUNTRY? <u>ENGLAND</u>	
13. FATHER'S NAME <u>Thomas Wilkinson</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-2501</u>	
17. INFORMANT <u>Mrs Nancy Brown McHale</u>		Address <u>3755 Benton St N.W. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) Essential Hypertension (20 yrs.); Generalized Arteriosclerosis</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>very young</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. j. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>41</u> , to <u>April 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 4</u> , 19 <u>60</u> , and that death occurred at <u>2:18 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Bertram F. Schaefer</u> M.D. <u>1780 Massachusetts Ave. N.W. 4/5/60</u> PHYSICIAN'S NAME (Type) <u>Bertram F. Schaefer M.D.</u> <u>Wash. D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-8-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) <u>Suitland</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. De Vol</u>		ADDRESS <u>2224 Wis. Ave. D.C.</u>	
24a. REC'D BY REGISTRAR <u>APR 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

CERTIFICATE OF DEATH

1. PLACE OF DEATH Home		2. DISTRICT Baltimore		3. COUNTY Baltimore	
4. CITY OR TOWN Baltimore		5. STREET 1234 N. Broadway		6. HOUSE NO. 1234	
7. SEX Male		8. AGE 45		9. OCCUPATION Teacher	
10. MARITAL STATUS Married		11. DATE OF BIRTH 1910-11-15		12. DATE OF DEATH 1955-11-15	
13. CAUSE OF DEATH Heart Disease		14. PLACE OF BIRTH Maryland		15. PLACE OF DEATH Home	
16. DATE OF DEATH 1955-11-15		17. TIME OF DEATH 10:00 AM		18. PLACE OF DEATH Home	
19. NAME OF DECEASED John Doe		20. NAME OF NEXT OF KIN Jane Doe		21. NAME OF PHYSICIAN Dr. Smith	
22. NAME OF BURIAL PLACE Catholic Cemetery		23. NAME OF MINISTER Rev. Mr. Jones		24. NAME OF FUNERAL HOME Doe Funeral Home	
25. NAME OF CEMETERY Catholic Cemetery		26. NAME OF MINISTER Rev. Mr. Jones		27. NAME OF FUNERAL HOME Doe Funeral Home	
28. NAME OF CEMETERY Catholic Cemetery		29. NAME OF MINISTER Rev. Mr. Jones		30. NAME OF FUNERAL HOME Doe Funeral Home	
31. NAME OF CEMETERY Catholic Cemetery		32. NAME OF MINISTER Rev. Mr. Jones		33. NAME OF FUNERAL HOME Doe Funeral Home	
34. NAME OF CEMETERY Catholic Cemetery		35. NAME OF MINISTER Rev. Mr. Jones		36. NAME OF FUNERAL HOME Doe Funeral Home	
37. NAME OF CEMETERY Catholic Cemetery		38. NAME OF MINISTER Rev. Mr. Jones		39. NAME OF FUNERAL HOME Doe Funeral Home	
40. NAME OF CEMETERY Catholic Cemetery		41. NAME OF MINISTER Rev. Mr. Jones		42. NAME OF FUNERAL HOME Doe Funeral Home	
43. NAME OF CEMETERY Catholic Cemetery		44. NAME OF MINISTER Rev. Mr. Jones		45. NAME OF FUNERAL HOME Doe Funeral Home	
46. NAME OF CEMETERY Catholic Cemetery		47. NAME OF MINISTER Rev. Mr. Jones		48. NAME OF FUNERAL HOME Doe Funeral Home	
49. NAME OF CEMETERY Catholic Cemetery		50. NAME OF MINISTER Rev. Mr. Jones		51. NAME OF FUNERAL HOME Doe Funeral Home	
52. NAME OF CEMETERY Catholic Cemetery		53. NAME OF MINISTER Rev. Mr. Jones		54. NAME OF FUNERAL HOME Doe Funeral Home	
55. NAME OF CEMETERY Catholic Cemetery		56. NAME OF MINISTER Rev. Mr. Jones		57. NAME OF FUNERAL HOME Doe Funeral Home	
58. NAME OF CEMETERY Catholic Cemetery		59. NAME OF MINISTER Rev. Mr. Jones		60. NAME OF FUNERAL HOME Doe Funeral Home	
61. NAME OF CEMETERY Catholic Cemetery		62. NAME OF MINISTER Rev. Mr. Jones		63. NAME OF FUNERAL HOME Doe Funeral Home	
64. NAME OF CEMETERY Catholic Cemetery		65. NAME OF MINISTER Rev. Mr. Jones		66. NAME OF FUNERAL HOME Doe Funeral Home	
67. NAME OF CEMETERY Catholic Cemetery		68. NAME OF MINISTER Rev. Mr. Jones		69. NAME OF FUNERAL HOME Doe Funeral Home	
70. NAME OF CEMETERY Catholic Cemetery		71. NAME OF MINISTER Rev. Mr. Jones		72. NAME OF FUNERAL HOME Doe Funeral Home	
73. NAME OF CEMETERY Catholic Cemetery		74. NAME OF MINISTER Rev. Mr. Jones		75. NAME OF FUNERAL HOME Doe Funeral Home	
76. NAME OF CEMETERY Catholic Cemetery		77. NAME OF MINISTER Rev. Mr. Jones		78. NAME OF FUNERAL HOME Doe Funeral Home	
79. NAME OF CEMETERY Catholic Cemetery		80. NAME OF MINISTER Rev. Mr. Jones		81. NAME OF FUNERAL HOME Doe Funeral Home	
82. NAME OF CEMETERY Catholic Cemetery		83. NAME OF MINISTER Rev. Mr. Jones		84. NAME OF FUNERAL HOME Doe Funeral Home	
85. NAME OF CEMETERY Catholic Cemetery		86. NAME OF MINISTER Rev. Mr. Jones		87. NAME OF FUNERAL HOME Doe Funeral Home	
88. NAME OF CEMETERY Catholic Cemetery		89. NAME OF MINISTER Rev. Mr. Jones		90. NAME OF FUNERAL HOME Doe Funeral Home	
91. NAME OF CEMETERY Catholic Cemetery		92. NAME OF MINISTER Rev. Mr. Jones		93. NAME OF FUNERAL HOME Doe Funeral Home	
94. NAME OF CEMETERY Catholic Cemetery		95. NAME OF MINISTER Rev. Mr. Jones		96. NAME OF FUNERAL HOME Doe Funeral Home	
97. NAME OF CEMETERY Catholic Cemetery		98. NAME OF MINISTER Rev. Mr. Jones		99. NAME OF FUNERAL HOME Doe Funeral Home	
100. NAME OF CEMETERY Catholic Cemetery		101. NAME OF MINISTER Rev. Mr. Jones		102. NAME OF FUNERAL HOME Doe Funeral Home	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4743

4641

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Harrisburg</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>25 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harrisburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>1823 Mulberry Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sara Elva BROWN</b>				4. DATE OF DEATH Month Day Year <b>April 16 19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-8-13</b>	
9. AGE (In years lost birthday) yrs. <b>47</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John BROWN</b>		14. MOTHER'S MAIDEN NAME <b>Mable YEAGER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1943 to 1960</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>uremia</b> <b>175.0</b> DUE TO <b>ureteral obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastatic ovarian carcinoma</b> (c) <b>Metastatic ovarian carcinoma</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>personally</del> attended the deceased from <b>March 22 19 60</b> to <b>April 16 19 60</b> , that (I) <del>did</del> saw the deceased alive on <b>April 16 19 60</b> , and that death occurred at <b>10 A M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Joseph A. Murgalo</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-17-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joseph A. MURGALO, LT, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-21-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>				ADDRESS <b>W.W. Chambers Funeral Home, 3072 M St, NW, Wash DC</b>		25a. REC'D BY REGISTRAR <b>APR 21 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

64642

4744

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>48 Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4858 Battery Lane</b>		e. STREET ADDRESS <b>4858 Battery Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>J.</b> Last <b>BROWNING</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 4, 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>5</b> Days <b>7</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Robert S. Morris</b>		14. MOTHER'S MAIDEN NAME <b>Sally Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Daughter</b> Address <b>Maryland</b>		<b>Virginia Hudson-10012 Sinnot Dr. Beth</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X Central Thrombosis</b> DUE TO <b>Hypertension Heart Mus.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO <b></b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 days 15 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>1960 APRIL 11</b> to <b>APRIL 11, 1960</b> that (I) (we) saw the deceased alive on <b>APRIL 11, 1960</b> and that death occurred at <b>1:00 PM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>P. L. Tabb, M.D.</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>S. L. TABB, M.D.</b>		22b. DATE SIGNED <b>4/11/60</b>	
22d. ADDRESS <b>13000 GA. AVE S.W. Sp. 170</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/14/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Prince George Co. Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 12 '60</b> 25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	



4200

64643

4745

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. LENGTH OF STAY IN TB <u>18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>				e. STREET ADDRESS <u>9620 Bethill Dr.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>S</u> Last <u>Brust</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 1 1877</u>	
9. AGE (In years lost birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Fredrick Md</u>	
13. FATHER'S NAME <u>George Ketter</u>				14. MOTHER'S MAIDEN NAME <u>Annie Seibert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT <u>Mrs C.E. Phillips 9620 Bethill Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>AGE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>15 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>45</u> , to <u>April</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 26</u> , 19 <u>60</u> , and that death occurred at <u>5:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo I O'Donovan M.D.</u>				ADDRESS (Street, city or town, state) <u>8218-WISCONSIN AVE</u>			
PHYSICIAN'S NAME (Type) <u>LEO I O'DONOVAN M.D.</u>				DATE SIGNED <u>4/26/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-29-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dean Funeral Home</u>				ADDRESS <u>4812 9a. Ave</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 3 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knepp</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 4, 8, 9 & 14 Film G262 5/6/60 iwk

64644

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Redland, Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Martinsburg, Md</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ammonds Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Butler</b> Last <b>Butler</b>		4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>unknown</b>
9. AGE (In years last birthday) <b>Approx 75 yrs.</b>		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Martinsburg, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emanuel Butler</b>		14. MOTHER'S MAIDEN NAME <b>Eve ? unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>Mrs Emma McPherson Washington D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure.</b> DUE TO <b>151X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of stomach</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January, 1960</b> , to <b>April 28, 1960</b> , that I last saw the deceased alive on <b>April 23, 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Luciano P. Leal</b> M.D.		ADDRESS (Street, city or town, state) <b>Gaithersburg, Md.</b>	
DATE SIGNED <b>Luciano P. Leal</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/1/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Martinsburg, Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Martinsburg, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>		ADDRESS <b>Rockville, Md</b>	
24a. REC'D BY REGISTRAR <b>MAY 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

CERTIFICATE OF DEATH

1946

Warrant for the  
arrest of the

James A. Lee  
born 1913  
died 1946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
M  
4747  
M  
1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

64645

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D. C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u> <u>47x-3</u>	
d. STREET ADDRESS <u>1682 Irving St., N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Velia</u> Middle <u>Rodriquez</u> Last <u>CARMONA</u>		4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-21-24</u>
9. AGE (In years last birthday) <u>35</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Chile</u>		12. CITIZEN OF WHAT COUNTRY? <u>Chile</u> <u>-</u>	
13. FATHER'S NAME <u>Waldo RODRIQUEZ</u>		14. MOTHER'S MAIDEN NAME <u>Caida BALLINI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebrovascular accident</u> DUE TO (c) <u>toxemia of pregnancy.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <u>this doctor</u> ) attended the deceased from <u>April 26</u> <u>1960</u> to <u>April 27</u> <u>1960</u> , that (I) ( <u>xx</u> ) last saw the deceased alive on <u>April 27</u> <u>1960</u> , and that death occurred at <u>9:14 AM</u> , from the causes and on the date stated above.		22a. SIGNATURE <u>James Austin</u>	
22b. DATE SIGNED <u>4-27-60</u>		22c. PHYSICIAN'S NAME (Type) <u>J. A. AUSTIN, LT, MC, USN</u>	
22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Shipment</u>		23b. DATE THEREOF <u>  </u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>		23d. LOCATION (City, town, or county) (State) <u>Santiago Chile</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Humphrey</u>		25a. REC'D BY REGISTRAR <u>APR 29 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>		25c. ADDRESS <u>R. A. Humphrey Funeral Home, Bethesda, Maryland</u>	



1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

4748

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Ruth</b> Last <b>Carothers</b>				4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 17, 1920</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Charles Hoak</b>				14. MOTHER'S MAIDEN NAME <b>Sue Markel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>172-14-6672</b>			
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> DUE TO <b>410X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mitral Stenosis</b> DUE TO (c) <b>Rheumatic Heart Disease</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>13 years</b> <b>13 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Anesthesia induction</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 27</b> , 19 <b>60</b> , to <b>April 6</b> , 19 <b>60</b> that I last saw the deceased alive on <b>April 6</b> , 19 <b>60</b> , and that death occurred at <b>1:32 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b> DATE SIGNED <b>4/6/60</b>							
ACTUAL SIGNATURE <b>Lazar J. Greenfield, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Lazar J. Greenfield, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>				22b. DATE THEREOF <b>4/7/60</b>		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county) (State) <b>Elizabeth, Pa.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1150	1151	1152	1153	1154	1155	1156	1157	1158	1159	1160	1161	1162	1163	1164	1165	1166	1167	1168	1169	1170	1171	1172	1173	1174	1175	1176	1177	1178	1179	1180	1181	1182	1183	1184	1185	1186	1187	1188	1189	1190	1191	1192	1193	1194	1195	1196	1197	1198	1199	1200	1201	1202	1203	1204	1205	1206	1207	1208	1209	1210	1211	1212	1213	1214	1215	1216	1217	1218	1219	1220	1221	1222	1223	1224	1225	1226	1227	1228	1229	1230	1231	1232	1233	1234	1235	1236	1237	1238	1239	1240	1241	1242	1243	1244	1245	1246	1247	1248	1249	1250	1251	1252	1253	1254	1255	1256	1257	1258	1259	1260	1261	1262	1263	1264	1265	1266	1267	1268	1269	1270	1271	1272	1273	1274	1275	1276	1277	1278	1279	1280	1281	1282	1283	1284	1285	1286	1287	1288	1289	1290	1291	1292	1293	1294	1295	1296	1297	1298	1299	1300	1301	1302	1303	1304	1305	1306	1307	1308	1309	1310	1311	1312	1313	1314	1315	1316	1317	1318	1319	1320	1321	1322	1323	1324	1325	1326	1327	1328	1329	1330	1331	1332	1333	1334	1335	1336	1337	1338	1339	1340	1341	1342	1343	1344	1345	1346	1347	1348	1349	1350	1351	1352	1353	1354	1355	1356	1357	1358	1359	1360	1361	1362	1363	1364	1365	1366	1367	1368	1369	1370	1371	1372	1373	1374	1375	1376	1377	1378	1379	1380	1381	1382	1383	1384	1385	1386	1387	1388	1389	1390	1391	1392	1393	1394	1395	1396	1397	1398	1399	1400	1401	1402	1403	1404	1405	1406	1407	1408	1409	1410	1411	1412	1413	1414	1415	1416	1417	1418	1419	1420	1421	1422	1423	1424	1425	1426	1427	1428	1429	1430	1431	1432	1433	1434	1435	1436	1437	1438	1439	1440	1441	1442	1443	1444	1445	1446	1447	1448	1449	1450	1451	1452	1453	1454	1455	1456	1457	1458	1459	1460	1461	1462	1463	1464	1465	1466	1467	1468	1469	1470	1471	1472	1473	1474	1475	1476	1477	1478	1479	1480	1481	1482	1483	1484	1485	1486	1487	1488	1489	1490	1491
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------	------

4749

## CERTIFICATE OF DEATH

Reg. Dist. No.

04647

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Rockville</u>			
c. LENGTH OF STAY in 1b <u>19 days</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				1d. STREET ADDRESS <u>505-Bickford Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nellie E Carpenter</u>				4. DATE OF DEATH <u>April 27 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 26, 1907</u>	
9. AGE (in years last birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Jack Burke</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Cooper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>Mary Curtis</u> Address <u>505 Bickford Lane</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>600.0</u> DUE TO <u>uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic pyelonephritis</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3+ weeks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-18</u> , 19 <u>60</u> , to <u>—</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>4-27</u> , 19 <u>60</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>BLAINE H. EIG.</u>				ADDRESS (Street, city or town, state) <u>2641 Glenwood</u> DATE SIGNED <u>Apr 28, 1960</u>			
PHYSICIAN'S NAME (Type) <u>BLAINE H. EIG.</u>				M.D. <u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipped</u>		22b. DATE THEREOF <u>4/29/60</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Orange, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville Md</u>				24a. REC'D BY REGISTRAR <u>MAY 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1749

AGE 25

*[Faint, mostly illegible text from the body of the certificate, including fields for name, date, and cause of death.]*

4750

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nita</b> Middle <b>B.</b> Last <b>Carrigan</b>				4. DATE OF DEATH Month <b>April</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/28/71</b>		9. AGE (In years lost birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>Westminister, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Thomas Jefferson Hardesty</b>			
14. MOTHER'S MAIDEN NAME <b>Frances Miller</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>None</b>				INFORMANT <b>5519 Wootton Ave., Friendship Hgts. Md.</b> (Son) <b>Mr. W.T. Carrigan</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes</b> DUE TO (c) <b>Old Age</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Two Hours</b> <b>Many Years</b> <b>Age 88</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 2, 1956</b> to <b>April 25, 1960</b> that I last saw the deceased alive on <b>April 25, 1960</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Bradley Hodgkins</b> M.D.				ADDRESS (Street, city or town, state) <b>4413 Bradley Lane</b> DATE SIGNED <b>4/25/60</b>			
PHYSICIAN'S NAME (Type) <b>B.D. Hodgkins</b>				<b>Cherry Chase 15 Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/28/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WERNER E. PIMPHREY, INC.</b> <b>Raymond B. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>APR 27 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



CERTIFICATE OF DEATH

1750

RECEIVED



Montgomery

Alabama

4 days

Washington

Suburban

Carlisle

B.

White

W. S. W.

White

Female

White

White

Thomas Jefferson University  
Baptist Hospital, Wash. D.C.

Thomas Jefferson University

White

Male

*Handwritten signature and text, mostly illegible.*

W. S. W.

W. S. W.

W. S. W.

W. S. W.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4717 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64649

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3507 FARRAGUT ST.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 KENSINGTON	
f. STREET ADDRESS 3507 FARRAGUT ST.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELIZABETH B. CASEY		4. DATE OF DEATH Month Day Year APRIL 6 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1/76
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) WILSON, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN ROWAN		14. MOTHER'S MAIDEN NAME MARY KEARNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address Mr. James E. Casey, 3507 Farragut St. Kensington, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis (c) DUE TO cause lost. Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED 4/6/60	
EXAMINER'S NAME (Type) FRANK J. BROSCART		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/9/60	22c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	22d. LOCATION (City, town, or county) (State) Oakland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WARNER E. PUMPHREY, INC. SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE APR 8 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please, execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER		11. SIGNATURE OF WITNESS		12. SIGNATURE OF CORONER	



1995

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

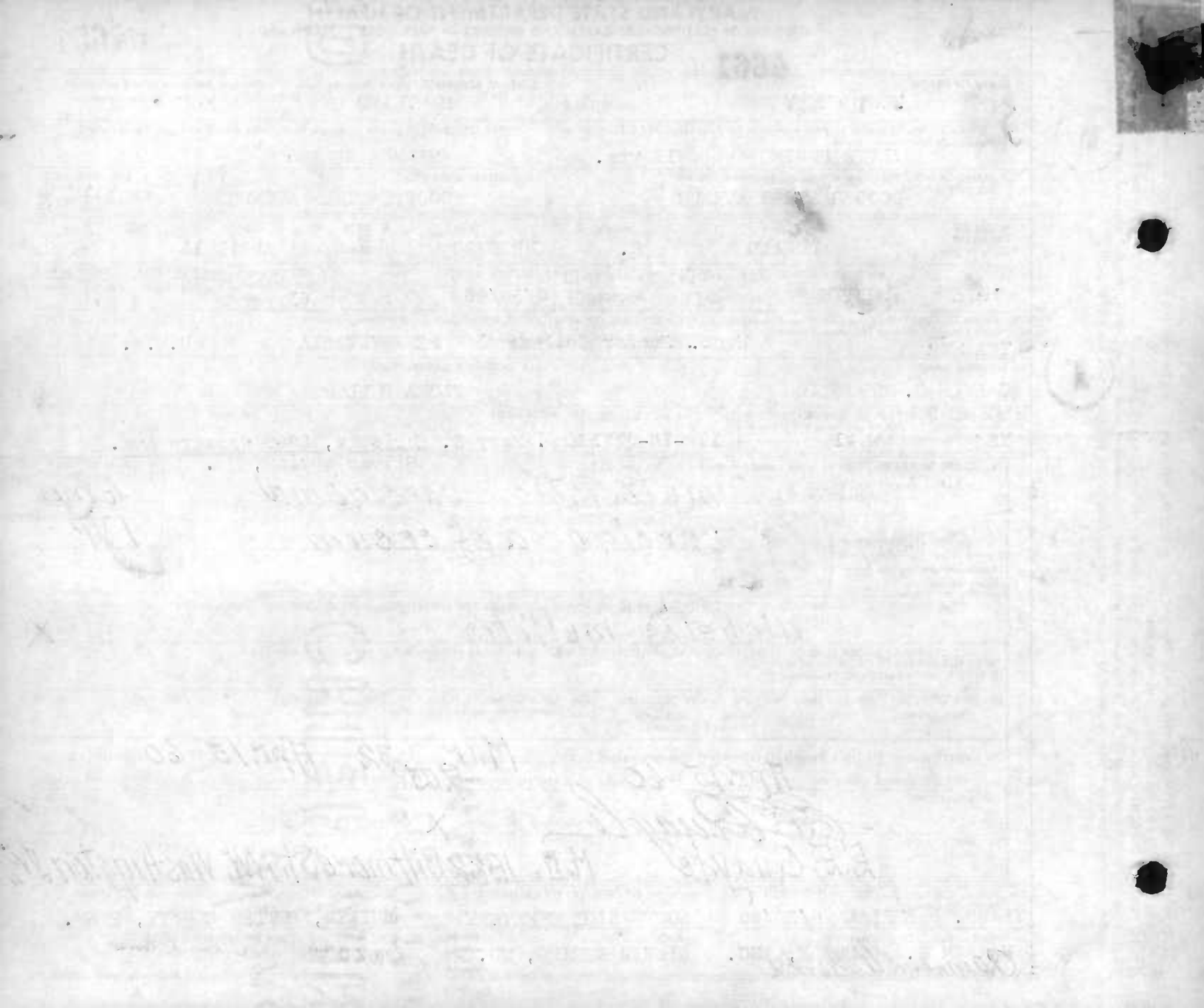
64651

4661

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>13 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8009 EASTERN AVENUE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DONALD</b> Middle <b>R.</b> Last <b>CHRISTIE</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>15</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/30/96</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mont. Junior College</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CALVIN G. CHRISTIE</b>				14. MOTHER'S MAIDEN NAME <b>FLORA BELL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>				16. SOCIAL SECURITY NO. <b>WW #1 178-18-0773</b>		17. INFORMANT <b>Mrs. Mary S. Christie, 8009 Eastern Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b> DUE TO <b>carcinoma of cecum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1 yr</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>diabetes mellitis</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 19 32</b> to <b>Apr 15 19 60</b> that (I) (we) last saw the deceased alive on <b>Apr 15 19 60</b> and that death occurred <b>2:05 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>E.E. Quayle</b> M.D.				22b. DATE SIGNED <b>APR 20 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>E.E. Quayle</b>				22d. ADDRESS <b>M.M. 1822 Biltmore St. NW. Washington, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		23b. DATE THEREOF <b>4/20/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NORTH SIDE CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>BUTLER, BUTLER COUNTY, PENN.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond J. Ziska</b>				25a. REC'D BY REGISTRAR <b>APR 20 1960</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For use by the funeral director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4752 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

64652

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Mont.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>48 Chevy Chase</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>		d. STREET ADDRESS <b>4740-Bradley Boulevard</b>	
3. NAME OF DECEASED (Type or print) <b>Peter</b> First <b>Chrzanowski</b> Middle <b>Chrzanowski</b> Last		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1910</b>
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physicist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bureau of Standards Conn.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John F. Chrzanowski</b>		14. MOTHER'S MAIDEN NAME <b>Marion S. Rustic</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Wife</b> Address <b>Item #2</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cornary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>Smolder</b>	
ACTUAL SIGNATURE <b>Frank J. Broschert</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. Broschert</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4-11-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-14-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Montgomery Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b> ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 13 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

4201

## 4753 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>51 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>5014 60th Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>John</b> Last <b>Cifizzari</b>				4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 16, 1956</b>	
9. AGE (In years lost birthday) <b>3</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Philip J. Cifizzari</b>				14. MOTHER'S MAIDEN NAME <b>Carol Wozney</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Obstruction &amp; Bronchiectasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cystic Fibrosis of the Pancreas</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 Years</b> <b>3 Years</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 2</b> , 19 <b>60</b> , to <b>April 22</b> , 19 <b>60</b> that I last saw the deceased alive on <b>April 22</b> , 19 <b>60</b> , and that death occurred at <b>7:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>George J. Bryan</b> M.D. <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>April 26 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) <b>Arlington, Va.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>4739 Balt. Ave, Hyattsville, Md.</b>							
24a. REC'D BY REGISTRAR DATE <b>APR 29 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Robert L. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the urban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1953

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]



11. Name of informant: [illegible]  
12. Address of informant: [illegible]  
13. Date of completion: [illegible]  
14. Signature of informant: [illegible]  
15. Date of completion: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

4686

64654

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>1728 Dennis Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <del>xxxxx</del> Middle <u>Lelia</u> Last <u>Clorella Clothier</u>				4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/26/90</u>	
9. AGE (If years lost birthday) <u>xx69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>xxxxx Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>xxxxxx Own home</u>		11. BIRTHPLACE (State or foreign country) <u>xx VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>us</u>	
13. FATHER'S NAME <u>David Clothier</u>				14. MOTHER'S MAIDEN NAME <u>xxxxxx IREA M. STEPHENSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Records</u>		Address <u>Washington Sanitarium</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>(HEMORRH)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 WK.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>17 APR 1960</u> to <u>18 APR 1960</u> that (I) (we) last saw the deceased alive on <u>18 APR 1960</u> and that death occurred <u>145PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>L. Marshall Cuvillier, Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/19/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. MARSHALL CUVILLIER, JR.</u>				22d. ADDRESS <u>1407 Woodside Pkwy., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/21/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MARSHALL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MARSHALL, VIRGINIA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WERNER E. PUMPHREY, INC.</u> <u>Raymond A. Zick</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>APR 21 60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	





may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4754

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

64655

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>51</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3227 Coquelin Terrace</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>VIRGINIA</b> Last <b>COUSTRY</b>				4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/1/15</b>		9. AGE (In years last birthday) <b>44</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>12</b>	IF UNDER 24 HRS. Hours <b>12</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Belgium</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Emile Sohie</b>				14. MOTHER'S MAIDEN NAME <b>Jeanne Van Orshaven</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Roger Coustry-Husband-same as 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.1 Congestive Heart Failure</b> DUE TO (b) <b>Generalized cancer chest.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>18 mos duration</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. ——— 19 p. m. ———		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1951</b> to <b>1960</b> , that (I) (we) last saw the deceased alive on <b>Apr. 13 1960</b> , and that death occurred at <b>3:55 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank B. Leslie</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Frank G. Leslie M.D.</b>	
22d. ADDRESS <b>8901 Ba. av. Silver Spring Md.</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/18/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION (City, town, or county) (State) <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Grand</b>	

APR 19 60

223

4687

CERTIFICATE OF DEATH

Reg. Dist. No.

4656

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tokoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b> 1649.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Oak Grove Convelescent Home</b>				d. STREET ADDRESS <b>2101 Ingraham Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Leslie</b> Last <b>Cox</b>				4. DATE OF DEATH Month <b>4</b> Day <b>18</b> Year <b>1960</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 23, 1875</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own Business</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Leonidas N. Cox</b>				14. MOTHER'S MAIDEN NAME <b>Hannah Anderson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Paul L. Cox Hyattsville, Maryland.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 yrs +</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —
21. I certify that I attended the deceased from <b>11/7</b> , 19 <b>56</b> , to <b>4/19</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4/18</b> , 19 <b>60</b> , and that death occurred at <b>1:05</b> P.M. from the causes and on the date stated above.							DATE SIGNED <b>4/19/60</b>
ACTUAL SIGNATURE <b>Frank M Trozzo Jr.</b>				ADDRESS (Street, city or town, state) <b>3501 Hamilton St Hyattsville, Md</b>			
PHYSICIAN'S NAME (Type) <b>FRANK M TROZZO JR.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/23/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Goshen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Indiana, Goshen</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4755  
64657  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>713 Shetland Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Claude</b> Middle <b>Ernest</b> Last <b>CRAWFORD</b>				4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-10-96</b>	
9. AGE (In years, lost birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John CRAWFORD</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth BRIDGES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWI</b>		17. INFORMANT <b>(D) Mrs. Alice Gilmore, same as #2 above.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2.5 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial infarction - July 1958</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>physician</del> attended the deceased from <b>March 29</b> 19 <b>60</b> to <b>April 13</b> 19 <b>60</b> that (I) <del>did</del> <b>did</b> not see the deceased alive on <b>April 13</b> 19 <b>60</b> , and that death occurred at <b>5:25 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John Wood Davis</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-14-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>John Wood DAVIS, LT, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE THEREOF <b>4-18-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Columbus Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Middletown Rhode Island</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				ADDRESS <b>Funeral Home, Rockville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 18 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	



420.]

4756

## CERTIFICATE OF DEATH

Reg. Dist. No.

64658

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Alabama</b> b. COUNTY <b>Mobile</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mobile</b>		d. STREET ADDRESS <b>2366 West Curry Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mildred</b> Middle <b>Ruth</b> Last <b>Crawford</b>		4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 15, 1928</b>
9. AGE (In years lost birthday) yrs. <b>31</b>		IF UNDER 1 YEAR Months <b>31</b> Days <b>31</b> Hours <b>31</b> Min. <b>31</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None (Housewife)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas Nelson</b>		14. MOTHER'S MAIDEN NAME <b>Mity Pace</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>Cardiac Failure, following Operative closure of Atrial and Ventricular Septal Defects</b> INTERVAL BETWEEN ONSET AND DEATH <b>34 Hours</b>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 27</b> , 19 <b>60</b> , to <b>April 9</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 9</b> , 19 <b>60</b> , and that death occurred at <b>11:00 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Roland Folse</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4-10-60</b>	
PHYSICIAN'S NAME (Type) <b>ROLAND FOLSE, M.D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 4/11/60</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>		22d. LOCATION (City, town, or county) (State) <b>Mobile, Alabama</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>APR 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Department of the Interior

Geological Survey

Washington

June 15, 1905

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 10th inst.

relative to the matter of the proposed extension of the

boundary of the National Monument, and in reply to inform you

that the same has been referred to the proper authorities for their

consideration.

Very respectfully,

Wm. H. Woodworth, Chief of Division

Enclosure

Very truly yours,  
Wm. H. Woodworth, Chief of Division  
Geological Survey, Department of the Interior  
Washington, D. C.

1775

June 15, 1905

Chief of Division

1-10-05

The National Monument

Department of the Interior

Washington, D. C.

Very truly yours,

Wm. H. Woodworth, Chief of Division

Geological Survey, Department of the Interior

4757

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Ohio</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		d. STREET ADDRESS <b>1357 Jackson Pike</b>	
3. NAME OF DECEASED (Type or print) First <b>King</b> Middle <b>Sheridan</b> Last <b>Davis</b>		4. DATE OF DEATH Month <b>4</b> Day <b>20</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/4/08</b>
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months <b>51</b> Days <b>19</b> Hours <b>60</b> Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Iron Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	11. BIRTHPLACE (State or foreign country) <b>Pilgrim, Kentucky</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Tee Davis</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Thrombosis</b> (c) <b>Coronary Arteriosclerosis</b> DUE TO cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Collapsed while working on construction job</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 4-21-60</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Davis Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Martin County, Kentucky</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF KENTUCKY  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Blank]		SEX [Blank]		AGE [Blank]	
RACE [Blank]		OCCUPATION [Blank]		PLACE OF BIRTH [Blank]	
DATE OF DEATH [Blank]		TIME OF DEATH [Blank]		PLACE OF DEATH [Blank]	
CAUSE OF DEATH [Blank]		MANNER OF DEATH [Blank]		SIGNATURE OF EXAMINER [Blank]	
COUNTY [Blank]		CITY [Blank]		STATE [Blank]	

4758

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Annapurda</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>				c. LENGTH OF STAY IN 1b <u>5 1/2 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard Hicks Davis</u>				4. DATE OF DEATH Month Day Year <u>April 22 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 14, 1899</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. Ret.</u>			
13. FATHER'S NAME <u>Frank Higdon</u>				14. MOTHER'S MAIDEN NAME <u>Laura B Hicks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction, Massive</u> DUE TO (b) <u>Coronary Thrombosis, Posterior Coronary Artery</u> DUE TO (c) <u>Coronary Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>12 hours</u> <u>unknown</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-22-60</u> , 19 <u>60</u> at <u>4-22</u> that I last saw the deceased alive on <u>4-22-60</u> , 19 <u>60</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>13000 GA AVE. S-S. M.D.</u> DATE SIGNED <u>4/22/60</u>			
ACTUAL SIGNATURE <u>S. L. Tabb, M.D.</u>				M.D. <u>S. L. Tabb, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>S. L. TABB, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>26 April '60</u>		<u>Cedar Hill Cem</u>		<u>Suitland Md-</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> ADDRESS <u>300-A 3rd NE</u>				24a. REC'D BY REGISTRAR DATE <u>APR 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



David,

1

VS. A15ME  
5M 7/59

**MEDICAL CERTIFICATION**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>md</u>	
c. LENGTH OF STAY IN 1b <u>10 yrs 23</u>		d. STREET ADDRESS <u>Silver Spring</u>	
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8418 Piney Branch Ct</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Ludlow Decker</u>		4. DATE OF DEATH <u>April 11 1960</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-13-1897</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lawyer (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MORRIS C. DECKER</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE HOFFMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW #1</u>		16. SOCIAL SECURITY NO. <u>289-18-5142</u>	
17. INFORMANT <u>Mrs. Laurine C. Decker, 8418 Piney Br. Ct.</u>		Address <u>Silver Spring</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			
(b) <u>Myocardial infarction</u>			
(c) <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.V.A. Feb 1960</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCERT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-11-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR <u>WADSWORTH &amp; PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>APR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

420.1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

64662

4725

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>			c. LENGTH OF STAY IN 1b <u>4 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 ROCKVILLE</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12120 OTIS DR.</u>				d. STREET ADDRESS <u>12120 OTIS DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MICHAEL</u> Middle <u>F</u> Last <u>DEMPSEY</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 19 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>14</u> Min.		IF UNDER 24 HRS. Hours <u>14</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DE Government</u>		11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>MICHAEL Dempsey</u>				14. MOTHER'S MAIDEN NAME <u>UNK.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Joseph Dempsey</u> Address <u>1817 Longfellow St Hyattsville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adrenoleukotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral, Portal</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u> <u>24 HRS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>WASH DC</u> (County) <u></u> (State) <u></u>	
21. I certify that I attended the deceased from <u>march 2 1958</u> to <u>April 2 1960</u> , that I last saw the deceased alive on <u>April 2 1960</u> , and that death occurred at <u>4:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. L. TABB, M.D.</u>				ADDRESS (Street, city or town, state) <u>13000 GEORGIA AVE S.E. WASH. D.C.</u>			
PHYSICIAN'S NAME (Type) <u>S. L. TABB, M.D.</u>				DATE SIGNED <u>4/2/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>WASH DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. ATTORRELL</u>				ADDRESS <u>3603 14th NW WASH DC</u>		24a. REC'D BY REGISTRAR DATE <u>APR 4 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4726

64663

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> c. LENGTH OF STAY IN 1b <b>LIFE</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>325 LINCOLN STREET</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> d. STREET ADDRESS <b>325 LINCOLN ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BETTY JANE</b>		4. DATE OF DEATH <b>APRIL 4 19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>COL.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/22/59</b>
9. AGE (In years last birthday) <b>20</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JAMES H. BROWN</b>		14. MOTHER'S MAIDEN NAME <b>TRECIA DINGS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <b>POLICE RECORD</b>	
17. INFORMANT <b>88</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPHYXIA</b> <b>475X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>UPPER RESPIRATORY INFECTION</b> (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>475X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 HR.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART, M. D.</b>		DATE SIGNED <b>4/4/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or country) (State)
<b>Burial</b>	<b>4/7/60</b>	<b>County Home.,</b>	<b>Rockville, Md.</b>
23. FUNERAL DIRECTOR ADDRESS <b>Robert L. Sander</b> <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 13 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>

MEDICAL CERTIFICATION

2074309XV 6



475X

1

JAMES H. BROWN

SELECT RECORD

UPPER RESPIRATORY INFECTION

ALPHABETIC

JESSIE B. BROWN

MARYLAND

USA

XX

10

BIRDS

JANE

BETTY

FEMALE

COL.

25 LINCOLN ST.

25 LINCOLN ST.

BONVILLE

1955

NO. 1111

MARYLAND

BONVILLE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Mass.</u> b. COUNTY <u>Norfolk</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westmoreland Hills 16</u>		c. LENGTH OF STAY IN 1b <u>3 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5235 Duval Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sibyl</u> First <u>Webb</u> Middle <u>Dougherty</u> Last		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 29, 1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER OF VOICE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>SPRINGFIELD, OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN GROVER WEBB</u>		14. MOTHER'S MAIDEN NAME <u>GLENNA COLEMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>023 03 0281</u>	
17. INFORMANT <u>DAUGHTER, MRS. VIRGINIA GLOVER</u> Address <u>5235 DUVAL WESTMORELAND HILLS DRIVE MD.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>VENOUS THROMBOSIS</u> DUE TO (c) <u>CARCINOMA OF PANCREAS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>ONE HOUR</u> <u>2 DAYS</u> <u>1 YEAR</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 18, 1959</u> to <u>APRIL 5, 1960</u> , that I last saw the deceased alive on <u>APRIL 5, 1960</u> , and that death occurred at <u>9:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. G. Mac Murray</u> M.D.		ADDRESS (Street, city or town, state) <u>1150 CONN. AVE., NW, WASH 6, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>F. G. MAC MURRAY</u>		DATE SIGNED <u>APRIL 5, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>4-6-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons 1756 PA. AVE. N.W.</u>		ADDRESS <u>WASH 6, D.C.</u>	
24a. REC'D BY REGISTRAR <u>APR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4750 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64665  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>12616 Lehill Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Levi</u> Middle <u>F.</u> Last <u>Doye</u>		4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 12 1897</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Doye</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>4375-15 and 1115</u>	
17. INFORMANT <u>James Doye - Washington D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aorta</u> DUE TO <u>910.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Crushed Chest</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of pelvis</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Struck by falling tree while cutting it down</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by falling tree while cutting it down</u>		20c. TIME OF INJURY Month, Day, Year <u>11:28</u> o. m. <u>4/5/60</u>	
20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	
20f. (City or town) <u>Bethesda</u>		(County) <u>Montg. Md.</u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4/5/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/11/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National,</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swonder</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

7102

4761

## CERTIFICATE OF DEATH

64666

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark</b> 67X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>407 North 5th Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Paula</b> Middle <b>Ann</b> Last <b>Drake</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> , Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1959</b>		9. AGE (In years lost birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William E. Drake</b>				14. MOTHER'S MAIDEN NAME <b>Grace Dillworth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Wilm's tumor</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 12, 1960</b> to <b>April 16, 1960</b> , that I last saw the deceased alive on <b>April 16, 1960</b> , and that death occurred at <b>12:45A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/16/60</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <b>Lawrence A. Gaydos</b> M.D.				PHYSICIAN'S NAME (Type) <b>LAWRENCE A. GAYDOS, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>4-20-60</b>		<b>Glendale Cemetery</b>		<b>Bloomfield N. J.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James C. Chm...</b>				24a. REC'D BY REGISTRAR DATE <b>APR 19 60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



THE NATIONAL GUARDIAN, LONDON, 19th APRIL 1952

From the Editor, The National Guardian, London, 19th April 1952

Dear Sir,

I have your letter of the 18th inst. regarding the article in your issue of the 17th inst. concerning the activities of the "British Union for the Preservation of the White Race".

I am sorry that I cannot give you a more definitive answer at this time, but the matter is being dealt with by the appropriate authorities.

Yours faithfully,

John G. Jones

2 copies

19th April 1952

12:30

The National Guardian  
National Institute of Racial  
Education, 10, Bedford Square, London, W.C.1

Enclosed for you are 2 copies of the article in question.

Yours faithfully,

John G. Jones

4762

CERTIFICATE OF DEATH

Reg. Dist. No.

64667

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>131 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>Byron</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>49X-3</b> d. STREET ADDRESS <b>No street address</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>David Clayton Dunbar, Jr.</b>				4. DATE OF DEATH Month Day Year <b>April 23 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 5, 1933</b>	
9. AGE (In years lost birthday) <b>27</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Veterinarian</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Air Force</b>		11. BIRTHPLACE (State or foreign country) <b>Florida</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>David C. Dunbar, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Anne Snow</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>Yes Presently</b>				16. SOCIAL SECURITY NO. <b>258-50-4734</b>			
INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant melanoma with cerebral and pulmonary metastasis</b> 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>December 14, 1959</b> to <b>April 23, 1960</b> that I last saw the deceased alive on <b>April 23, 1960</b> , and that death occurred at <b>3:55A</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Arthur R. Rothman, M.D. The Clinical Center 4/23/60</b> <b>National Institutes of Health Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>4/27/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harts Mortuary</b>	
22d. LOCATION (City, town, or county) (State) <b>MACON GEORGIA</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rinaldi Funeral Home</b>				24a. REC'D BY REGISTRAR <b>APR 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ATTEST

Notary Public for the State of Georgia  
My commission expires on the 1st day of May, 1933.  
I hereby certify that the within and foregoing is a true and correct copy of the original of the within and foregoing as the same appears in the records of the office of the Notary Public for the State of Georgia.

Witness my hand and the seal of my office this 1st day of April, 1933.  
Notary Public for the State of Georgia  
My commission expires on the 1st day of May, 1933.  
I hereby certify that the within and foregoing is a true and correct copy of the original of the within and foregoing as the same appears in the records of the office of the Notary Public for the State of Georgia.

Notary Public for the State of Georgia  
My commission expires on the 1st day of May, 1933.  
I hereby certify that the within and foregoing is a true and correct copy of the original of the within and foregoing as the same appears in the records of the office of the Notary Public for the State of Georgia.

1 ~~XX~~  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**4763** **CERTIFICATE OF DEATH** **64668**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>MONT.</b> <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>59 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park 12</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>10713 Weymouth Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harrill</b> Middle <b>Stras</b> Last <b>DYER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-9-92</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chaplain</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William M. Dyer</b>				14. MOTHER'S MAIDEN NAME <b>Wilhelmina Fiege</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1917 to 1944</b>		17. INFORMANT <b>(W) Mrs. Louise R. Dyer, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>10 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>(was deceased)</del> attended the deceased from <b>Feb. 11</b> 19 <b>60</b> to <b>April 10</b> 19 <b>60</b> , that (I) <b>(x)</b> last saw the deceased alive on <b>April 9</b> 19 <b>60</b> and that death occurred at <b>4:55 am</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>F. J. Linehan Jr.</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-11-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. J. LINEHAN, JR., LCDR, MC, USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-13-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				ADDRESS <b>Funeral Home, Bethesda, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 12 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Richard S. Smith</b>			

MEDICAL CERTIFICATION

420

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4764

## CERTIFICATE OF DEATH

64669

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>New Jersey</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>28 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Margate City</b> 67X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>33 No. Clarendon Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Compton ECCLES</b>				4. DATE OF DEATH Month Day Year <b>April 25 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-18-00</b>	
9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Fred ECCLES</b>				14. MOTHER'S MAIDEN NAME <b>Clara DAGVILLE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>150-09-4048</b>		17. INFORMANT Address <b>(W) Edith B. Eccles, same as #2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma, rectum, with metastasis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Lung abscess, right upper lobe bronchus</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (XXXXXX) attended the deceased from <b>March 28 19 60</b> to <b>April 25 19 60</b> , that (I) <del>see</del> last saw the deceased alive on <b>April 25 1960</b> , and that death occurred at <b>6:40pm</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>K. M. Moser</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-26-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>K. M. MOSER, LT, MC, USNR</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE THEREOF <b>4-26-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>South Laurel Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Philadelphia Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b>				ADDRESS <b>1400 Chapin St., NW</b>		25a. REC'D BY REGISTRAR <b>APR 29 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



CERTIFICATE OF DEATH

(137)

1941

Name of Deceased		Date of Birth		Sex	
John Doe		1900-01-01		Male	
Place of Birth		Date of Death		Cause of Death	
New York City		1941-01-01		Heart Disease	
Occupation		Residence		Burial Place	
Teacher		123 Main St.		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issue		Official Seal	
1941-01-01		New York City		[Seal]	

4765

Items 9, 13, 14 Film G263 5-31-60 et

CERTIFICATE OF DEATH

64670

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Oak, Md</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>H.</b> Last <b>Ellison</b>				4. DATE OF DEATH Month <b>4/</b> Day <b>22/</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/15/1872</b>	
9. AGE (In years last birthday) <b>88 87 yrs.</b>		IF UNDER 1 YEAR Months <b>88</b> Days <b>87</b>		IF UNDER 24 HRS. Hours <b>88</b> Min. <b>87</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Nellie Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Diabetes Mellitus -</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>10 yrs</b> <b>24 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 8</b> , 19 <b>58</b> , to <b>April 22</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>3:00 AM 4/22 19 60</b> , and that death occurred at <b>3:01 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>9500 Colesville Rd Silver Spring Md</b> DATE SIGNED							
ACTUAL SIGNATURE <b>H B ORLEANS</b> M.D. <b>9500 Colesville Rd</b>				PHYSICIAN'S NAME (Type) <b>H B ORLEANS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Good Hope Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Colesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden Rockville, Md</b> ADDRESS				24a. REC'D BY REGISTRAR <b>APR 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased: [illegible]  
2. Date of birth: [illegible]  
3. Date of death: [illegible]  
4. Place of death: [illegible]  
5. Cause of death: [illegible]  
6. Signature of physician: [illegible]  
7. Signature of registrar: [illegible]  
8. Date of registration: [illegible]

4766

## CERTIFICATE OF DEATH

Reg. Dist. No.

64671

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>21 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Orange</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				67X-3			
3. NAME OF DECEASED (Type or print) First <b>Roger</b> Middle <b>David</b> Last <b>Engle, Jr.</b>				4. DATE OF DEATH Month <b>April</b> Day <b>30</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 20, 1943</b>	
9. AGE (In years lost birthday) yrs. <b>17</b>		IF UNDER 1 YEAR Months <b>17</b> Days <b>17</b> Hours <b>17</b> Min. <b>17</b>		IF UNDER 24 HRS. Months <b>17</b> Days <b>17</b> Hours <b>17</b> Min. <b>17</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Roger David Engle, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Melissa A. Eaton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hyperpotassemia</b> 754.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Renal and Myocardial failure</b> DUE TO (c) <b>Tetralogy of Fallot</b> INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b> <b>2 days</b> <b>Life</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 9</b> , 19 <b>60</b> , to <b>April 30</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 30</b> , 19 <b>60</b> , and that death occurred at <b>1:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/30/60</b> ACTUAL SIGNATURE <b>Robert D. Bloodwell</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Robert D. Bloodwell, M.D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removed</b>				22b. DATE THEREOF <b>April 30, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Montclair, N.J.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Chum</b>				ADDRESS <b>Arlington, Va.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 5 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Haines</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF BIRTH

4708

John Henry

1911

The District of Columbia, Washington, D.C.

John Henry

1911

The District of Columbia, Washington, D.C.

John Henry

1911

The District of Columbia, Washington, D.C.

The District of Columbia, Washington, D.C.

1911

John Henry

The District of Columbia, Washington, D.C.

John Henry

1911

1911

John Henry

The District of Columbia, Washington, D.C.

John Henry

1911

John Henry

4688

## CERTIFICATE OF DEATH

64672

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince Georges Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 1654.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>7209 Garland Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Edwin</u> Last <u>Evans III</u>		4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-6-59</u>
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Albert E. Evans Jr</u>	
14. MOTHER'S MAIDEN NAME <u>Patricia C. Flynn</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>	
16. SOCIAL SECURITY NO. <u></u>		INFORMANT Address <u>Mrs Patricia Flynn</u>	
18. CAUSE OF DEATH [Enter only one cause per time for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Broncho.</u> 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congenital Heart Disease, Type Unstetermined</u> DUE TO (c) <u>6 mo</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 <u>19</u> p. m. <u>None</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November, 1959</u> to <u>April, 12, 1960</u> that I last saw the deceased alive on <u>April 12th</u> 19 <u>60</u> , and that death occurred at <u>9:45</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Warren G. Preisser</u>		ADDRESS (Street, city or town, state) <u>8418 N. H. Ave. S.S., Md.</u> DATE SIGNED <u></u>	
PHYSICIAN'S NAME (Type) <u>WARREN G. PREISSER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>April 16, 1960</u>	<u>Fort Lincoln Crematory</u>	<u>Prince Georges Co. Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll H. NW D.C.</u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	
DATE <u>APR 18 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1922

Alfred E. Evans Jr.  
Born [illegible]  
Died [illegible]  
Cause of Death [illegible]  
Place of Death [illegible]  
Buried at [illegible]  
Funeral Home [illegible]

Witnessed by [illegible]  
Minister of the Gospel [illegible]  
Physician [illegible]  
Coroner [illegible]  
Date [illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No.

4718

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>5 months</u>		d. STREET ADDRESS <u>10808 Breewood St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>Petoia</u> Last <u>Ferrara</u>		4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 12, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Italy</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Raffaele Petoia</u>	
14. MOTHER'S MAIDEN NAME <u>ZEPA</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Alex Ferrara (son) 10808 Breewood St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1</u> , 19 <u>59</u> , to <u>April 1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 1</u> , 19 <u>60</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond Bradshaw</u> M.D.		ADDRESS (Street, city or town, state) <u>345 University Blvd, west</u> DATE SIGNED <u>4/1/60</u>	
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/4/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. DUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

State of New York  
County of ...  
I, the undersigned, a duly qualified and licensed ...  
do hereby certify that on the ... day of ...  
at the place of residence of the deceased, ...  
the following named person died ...  
Name of deceased ...  
Age ...  
Sex ...  
Race ...  
Cause of death ...  
Died at residence ...  
Buried at ...  
Signature of Registrar ...  
Signature of Physician ...  
Signature of Minister of the Gospel ...

4663

## CERTIFICATE OF DEATH

64674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Marilea Nursing Home</b>				e. STREET ADDRESS <b>1012 Elm Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>E</b> Last <b>Fields</b>				4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/4/1873</b>	9. AGE (In years lost birthday) <b>87</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>20</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Magruder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>578-10-7835B</b>			
17. INFORMANT <b>Daughter</b>				Address <b>Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CORONARY ARTERY DISEASE</b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 MINUTE</b> <b>10 YRS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHOLECYSTECTOMY - Jan 1959 - NEVER FULLY RECOVERED</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 19 <b>46</b> to <b>4/25</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4/23</b> , 19 <b>60</b> , and that death occurred at <b>1:45</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8218-WISC AVE</b> DATE SIGNED <b>4/25/60</b>							
ACTUAL SIGNATURE <b>Leo J. Donovan</b> M.D.				PHYSICIAN'S NAME (Type) <b>LEO J. DONOVAN MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/27/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 26 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED \_\_\_\_\_  
AGE \_\_\_\_\_  
SEX \_\_\_\_\_  
DATE OF DEATH \_\_\_\_\_

PLACE OF DEATH \_\_\_\_\_  
CAUSE OF DEATH \_\_\_\_\_  
MANNER OF DEATH \_\_\_\_\_

SIGNATURE OF DECEASED \_\_\_\_\_  
SIGNATURE OF WITNESSES \_\_\_\_\_  
SIGNATURE OF PHYSICIAN \_\_\_\_\_

DATE OF SIGNATURE \_\_\_\_\_  
PLACE OF SIGNATURE \_\_\_\_\_  
OFFICIAL \_\_\_\_\_  
TITLE \_\_\_\_\_

REMARKS \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4689

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Hrs. 2 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Washington Jan. &amp; Hospital</u>				d. STREET ADDRESS <u>19312 Weaver St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Feeda</u> Middle <u>ANN</u> Last <u>Forman</u>				4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-31-85</u>	
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> Hours <u>1</u> Min. <u>19</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>4</u> Hours <u>1</u> Min. <u>19</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wisconsin</u>		11. BIRTHPLACE (State or foreign country) <u>Amer.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>							
13. FATHER'S NAME <u>Jacob Blumberg</u>				14. MOTHER'S MAIDEN NAME <u>Libby Codner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Raymond Forman - 9312 Weaver St. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Several years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral Bronchopneumonia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March</u> , 1960, to <u>April 1</u> , 1960, that I last saw the deceased alive on <u>April 1 200 PM 1960</u> , and that death occurred at <u>7:03 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stuart L. Nelson</u>				DATE SIGNED <u>7600 Carroll Ave Takoma Park Md.</u>			
PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 3, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dargansky &amp; Sons</u> ADDRESS <u>Washington DC</u>				24a. REC'D BY REGISTRAR <u>APR 5 60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MASSACHUSETTS STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1988

01111

11/11/88

11/11/88

11/11/88

11/11/88

11/11/88

11/11/88

11/11/88

11/11/88

11/11/88

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 4664 CERTIFICATE OF DEATH

64676

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>1028 University Blvd.</u>	
3. NAME OF DECEASED (Type or print) <u>Mrs Hattie Moore Foxwell</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-24-73</u>
9. AGE (In years lost birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Solomon Foxwell</u>		14. MOTHER'S MAIDEN NAME <u>Lucy KIRBY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT- <u>Washington Sanitarium &amp; Hospital</u>		Address <u>Takoma Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>25 April, 1960</u> , that (I) (we) last saw the deceased alive on <u>25 April, 1960</u> , and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Russell B. Arnold</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4/25/60</u>
22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>		22d. ADDRESS <u>8801 Calverville Road, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 28 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Prince George Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>		ADDRESS <u>4812 Ga Ave N.W. D.C.</u>	25a. RECEIVED BY REGISTRAR DATE <u>MAY 3 '60</u>
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

STATE OF OHIO  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERIFICATE OF DEATH

1

NOV 20 1914  
AMV

4767  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>620 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. STREET ADDRESS <b>6523 Bannockburn Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Jules</b> Middle <b>(None)</b> Last <b>Freund</b>				4. DATE OF DEATH Month <b>April</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1890</b>		9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government Research</b>		11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Herman Freund</b>				14. MOTHER'S MAIDEN NAME <b>Sophie Johner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Pancreatic fat necrosis</b> DUE TO (c) <b>Multiple Myeloma</b>							INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b> <b>weeks</b> <b>weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>August 11, 1958</b> , to <b>April 22, 1960</b> , that I last saw the deceased alive on <b>April 22, 1960</b> , and that death occurred at <b>3:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/22/60</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <b>James M. Marsh</b>		M.D. <b>James M. Marsh, M.D.</b>		PHYSICIAN'S NAME (Type) <b>James M. Marsh, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>4/25/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 26 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]

11. Name of informant: [illegible]  
12. Address of informant: [illegible]  
13. Signature of informant: [illegible]  
14. Date of completion: [illegible]

15. Name of registrar: [illegible]  
16. Address of registrar: [illegible]  
17. Signature of registrar: [illegible]  
18. Date of registration: [illegible]

19. Name of medical officer: [illegible]  
20. Address of medical officer: [illegible]  
21. Signature of medical officer: [illegible]  
22. Date of medical examination: [illegible]

23. Name of coroner: [illegible]  
24. Address of coroner: [illegible]  
25. Signature of coroner: [illegible]  
26. Date of coroner's report: [illegible]

27. Name of funeral director: [illegible]  
28. Address of funeral director: [illegible]  
29. Signature of funeral director: [illegible]  
30. Date of funeral: [illegible]

4727 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>59 Kenwood Park</u>	
c. LENGTH OF STAY IN lb <u>D.O.A.</u>		d. STREET ADDRESS <u>6900 Chevy St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>White Flint Golf Course</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Samuel A. Friedman</u>		4. DATE OF DEATH <u>Apr 2 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-25-1916</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Louis Friedman</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Novick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>W. W. II</u>		16. SOCIAL SECURITY NO. <u>577-54-5096</u>	
17. INFORMANT <u>Mrs S.A. Friedman (wife)</u>		Address <u>Itan 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>4-2-60</u>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-6-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>	22d. LOCATION (City, town, or country) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR <u>B. DANZANSKY &amp; Sons - 3501-14th St. N.W.</u>		24a. REC'D BY REGISTRAR <u>APR 7 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			



THE STATE  
OF NEW YORK

IN SENATE  
January 11, 1900

REPORT  
OF THE

COMMISSIONER  
OF THE LAND OFFICE

IN RESPONSE  
TO A RESOLUTION  
PASSED BY THE SENATE  
MAY 1, 1899

ALBANY:

JOHN B. LANE, PRINTER.

1900.

100

100

100

100

100

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

64679

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. LENGTH OF STAY IN 1b <i>10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>806 Bowie Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>LeRoy</i> Last <i>Fullerton</i>		4. DATE OF DEATH Month <i>April</i> Day <i>26</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 27, 1896</i>
9. AGE (In years lost birthday) <i>63</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>operating engineer G.S.A. U.S. Gov.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>DuBois, Pa.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>not known</i>		14. MOTHER'S MAIDEN NAME <i>not known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Lois E Fullerton</i>		Address <i>806 Bowie Road, Rockville,</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>177X</i> IMMEDIATE CAUSE (a) <i>Carcinoma of the Prostate</i> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>4 mo.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1960</i> to <i>4-26</i> 1960 that (I) (we) last saw the deceased alive on <i>4-24</i> 1960 and that death occurred at <i>6:48</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Russell M. Tilley, D.</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>4701- Mass. Ave. N.W. Wash. D.C.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		23b. DATE THEREOF <i>April 29, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		23d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>C. J. Davis</i>		25a. REC'D BY REGISTRAR DATE <i>APR 28 '60</i>	
ADDRESS <i>Arlington, Va</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

1007

EXHIBIT A-10-DEATH

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

1007

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4768

CERTIFICATE OF DEATH

64680

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>28 days</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>		07X 2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>248 Laffey Circle - Apt. D</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Dorothy</b> Middle <b>Lynn</b> Last <b>GABLE</b>		<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>15</b> Year <b>19 60</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-12-58</b>	
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		
11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Howard Lee GABLE</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Ann ROBERTSON</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Hospital Records</b>		Address		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemia, lymphogenous, acute</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>204.3</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5-6 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mongolism</b>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <del>physician</del> attended the deceased from <b>March 18</b> 19 <b>60</b> to <b>April 15</b> 19 <b>60</b> , that (I) <del>was</del> last saw the deceased alive on <b>April 14</b> 19 <b>60</b> , and that death occurred on <b>April 15</b> 19 <b>60</b> at <b>9:25 am</b> , from the causes and on the date stated above.				
22a. SIGNATURE <b>Fred W Grello</b>		22b. DATE SIGNED <b>4-15-60</b>		
22c. PHYSICIAN'S NAME (Type) <b>Fred W. GRELO, LT, MC, USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		23b. DATE THEREOF <b>4-16-60</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>Shadow Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>LaGrange Georgia</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumpfrey</b>		25a. REC'D BY REGISTRAR <b>DATE Apr 21 '60</b>		
ADDRESS <b>R. A. Pumpfrey Funeral Home, Bethesda, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Christina L. House</b>		

CERTIFICATE OF DEATH

1234

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Signature of physician: [illegible]  
10. Signature of registrar: [illegible]  
11. Date of registration: [illegible]  
12. Place of registration: [illegible]

4769

## CERTIFICATE OF DEATH

64681  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suburban Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>3415 38th. Street N. W</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>H.</b> Last <b>Gall</b>				4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/31/87</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>V.A. Adm.</b>		11. BIRTHPLACE (State or foreign country) <b>Patterson N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Howard W. Gall</b>				14. MOTHER'S MAIDEN NAME <b>Eliz. Heaton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>(Sister) (Mae Greeland East Patterson, N.J.)</b> Address <b>173 Orchard St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC VASCULAR DISEASE</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>12 DAYS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>3-28, 1960</b> to <b>4-8, 1960</b> that I last saw the deceased alive on <b>4-8, 1960</b> , and that death occurred at <b>12:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edward W. Youngblood</b>				ADDRESS (Street, city or town, state) <b>WASHINGTON CLINIC, WASH. D. C.</b> DATE SIGNED <b>4-8-60</b>			
PHYSICIAN'S NAME (Type) <b>Edward Youngblood M.D.</b>				Washington Clinic, Wash. D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/12/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Grove Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Totowa, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey,</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 13 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knepp</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



420.1

## CERTIFICATE OF DEATH

v4682  
Reg. Dist. No.

4770

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Florida</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>48 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alphonse</b> Middle <b>Louis</b> Last <b>Girardin</b>				4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 20, 1912</b>	9. AGE (In years last birthday) <b>47</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Medical Doctor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Medical Practice</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alphonse L. Girardin</b>				14. MOTHER'S MAIDEN NAME <b>Sally Fry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Post- adrenalectomy</b> DUE TO (c) <b>Coronary artery disease with hypertension &amp; arterio sclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>30 min.</b> <b>48 hrs.</b> <b>6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>February 20, 1960</b> to <b>April 8, 1960</b> , that I last saw the deceased alive on <b>April 8, 1960</b> , and that death occurred at <b>6:45A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Norman H. Bell</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Norman H. Bell, M.D.</b>				DATE SIGNED <b>4/8/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transit</b>		22b. DATE THEREOF <b>4-8-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>--</b>		22d. LOCATION (City, town, or county) (State) <b>Ft. Myers, Florida</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY, Bethesda, Md.</b>				24a. REC'D BY REGISTRAR <b>APR 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

4733

11

Florida

Autopsy

Declared

18 days

18 days

Dr. Daniel Carter, Jacksonville, Fla.

Dr. Daniel Carter, Jacksonville, Fla.

Alphons

Latin

Latin

White

White

Medical Record

Medical Record

John A. Haver

John A. Haver

18

18

18

Cardiac arrest

30 min.

Post-mortem

18 min.

Cardiac arrest

18 min.

February 20, 1910

February 20, 1910

18

18

Robert H. Hall, M.D.

Robert H. Hall, M.D.

18

18

18

Robert A. Haver

Robert A. Haver

4771

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>1 5419 Duvall Drive</b>			
3. NAME OF DECEASED (Type or print) <b>Madeleine DeLand Goodwin</b>				4. DATE OF DEATH Month <b>4</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/13/18</b>		9. AGE (In years last birthday) <b>42</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Portland, Maine</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John H. Walzer</b>				14. MOTHER'S MAIDEN NAME <b>Susie May Morrison</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>450-52-2274</b>		INFORMANT <b>Arthur E. Goodwin, Jr.</b> <b>Husband</b> same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Primary site indeterminate</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>3/22/60</b> to <b>4/6/60</b> that I last saw the deceased alive on <b>4/6/60</b> and that death occurred at <b>12 PM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Albert S. Bright</b>				ADDRESS (Street, city or town, state) <b>8218 Wisconsin Ave Bethesda, MD</b>			
DATE SIGNED <b>4-6-60</b>							
PHYSICIAN'S NAME (Type) <b>Dr. Albert S. Bright</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 8, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 8 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. L. S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997

1000

9. *Journal of the American Medical Association*, 277, 1996, 1000-1001.

1991, 1992, 1993

ПОДЪЕМ НАБ. РАБОТ

End of CVX

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>16 Silver Spring</b> d. STREET ADDRESS <b>9603 Armistead Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harry Abraham Gottlieb</b>		4. DATE OF DEATH Month Day Year <b>April 3, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1907</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>10 12 00 00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wholesale Liquor</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Israel Gottlieb</b>		14. MOTHER'S MAIDEN NAME <b>Rose Poplinger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Frances Gottlieb-9603 Armistead Rd., S.S., Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Angina Pectoris</b> DUE TO (c) <b>1 1/2 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1 1/2 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1959</b> to <b>April 3, 1960</b> , that I last saw the deceased alive on <b>12 noon April 3, 1960</b> , and that death occurred at <b>12:15 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Max G. Shein M.D.</b> ADDRESS (Street, city or town, state) <b>2025 East West H'way Silver Spring, Md</b> DATE SIGNED <b>APR 5 '60</b> PHYSICIAN'S NAME (Type) <b>Max G. Shein, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-4-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Keshet Israel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hillside, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzansky</b>		24a. REC'D BY REGISTRAR DATE <b>APR 5 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur J. [Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1804605

4665

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONT.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1551 FALKLAND LANE</u>		d. STREET ADDRESS <u>1551 FALKLAND LANE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES K GRANT</u>		4. DATE OF DEATH Month Day Year <u>4 - 7 - 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 FEB. 1889</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days <u>2 3</u>	IF UNDER 24 HRS. Hours Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRAIN CONDUCTOR RAILROAD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MASS.</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN C. GRANT</u>		14. MOTHER'S MAIDEN NAME <u>ELLA DREW</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>SARAH R. GRANT</u>		Address <u>1551 FALKLAND LA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic insufficiency</u> <u>421.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) <u>undeterminable</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January, 1959</u> , to <u>April 7</u> , 1960, that I last saw the deceased alive on <u>March 25</u> , 1960, and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arnold Mc Pitt</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1835 Eye St., N.W., Wash. D.C.</u> <u>4/7/60</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-12-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Ft. Meyer, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Charles Jones</u>		24. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>	
25. ADDRESS <u>1750 16th St. N.W., Wash. D.C.</u>		26. REGISTRAR'S SIGNATURE <u>Charles E. Howard</u>	

421.1

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 4691 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64686

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN b <b>17</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>7139 Maple Ave.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>7139 Maple Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clinton William Graves</b>		4. DATE OF DEATH Month Day Year <b>Apr. 22, 1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/8/1917</b>
9. AGE (In years last birthday) <b>42</b>		10. IF UNDER 1 YEAR Months Days <b>19</b>	
11. IF UNDER 24 HRS. Hours Min. <b>19</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>Bessie L. Graves (wife)</b>	
17. INFORMANT <b>Bessie L. Graves (wife)</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Carbon monoxide poisoning</b> IMMEDIATE CAUSE (a) <b>973.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Found dead in running auto parked in rear yard of home with hose attached to exhaust extending thru window.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Found dead in running auto parked in rear yard of home with hose attached to exhaust extending thru window.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>4/22/60</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 25, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>West Augusta Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>West Augusta, Virginia</b>	
23. FUNERAL DIRECTOR <b>J. Arthur Walters, 254 Carroll St NW, D.C.</b>		24a. REC'D BY REGISTRAR <b>APR 25 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>			

4891 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED  
AGE  
SEX  
RACE  
DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

MODE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

MODE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

MODE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

MODE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

MODE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4772

Reg. Dist. No. 4687

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>33 Rockville</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13126 Superior ST.</u> d. STREET ADDRESS <u>Wheaton Woods</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Samuel</u> Middle <u>Edward</u> Last <u>Gray</u>				<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>16</u> Year <u>1960</u>																	
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>May 19, 1925</u>		<b>9. AGE</b> (In years last birthday) <u>34</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>10</u></td> <td><u>27</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>10</u>	<u>27</u>		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<u>10</u>	<u>27</u>																				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Criminal Investigator</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Treasury</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>													
<b>13. FATHER'S NAME</b> <u>Samuel Edward Gray</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Emma Josephine Golden</u>																	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.II</u>				<b>16. SOCIAL SECURITY NO.</b> <u>577-224518</u>		<b>17. INFORMANT</b> <u>Margaret A Gray</u> Address <u>13126 Superior</u>															
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Insufficiency</u> DUE TO (b) <u>Coronary Thrombosis Arteriosclerotic</u> (c) <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Sudden</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Kidneys - Cerebral edema</u> (b) <u>Unknown</u>																					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>																	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Hour <u>19</u> a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> Month, Day, Year <u>19</u>																	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)													
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																					
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschant</u> M.D.						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>															
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschant</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>															
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <u>4-17-1960</u>															
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>22b. DATE THEREOF</b> <u>4/19/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>			<b>22d. LOCATION (City, town, or county)</b> (State) <u>Arlington, Virginia</u>													
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>						<b>ADDRESS</b> <u>Bethesda, Maryland</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE</u> <u>Apr 19 '60</u>													
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. House</u>																					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4773

64688

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>OHIO</b> b. COUNTY <b>NORTH JACKSON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NORTH JACKSON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4501 TRAYMORE STREET</b>		d. STREET ADDRESS <b>4501 TRAYMORE STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>STANDLE</b> Middle <b>GREENAWALT</b> Last <b>CURTIS</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/8/78</b>
9. AGE (In years last birthday) yrs. <b>81</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>NORTH JACKSON, OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEVIE GREENAWALT</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>YES</b>	
17. INFORMANT <b>Mrs. Earl Soltz, 4501 Traymore St.</b>		Address <b>Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ventricular fibrillation</b> <b>420.0</b> DUE TO <b>arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>2 yrs.</b> (c) <b>chronic pulmonary emphysema and bronchiectasis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>chronic pulmonary emphysema and bronchiectasis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>10</b> p. m. <b>4 3 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Bethesda</b>		20f. (City or town) (County) (State) <b>Ind.</b>	
21. I certify that (I) (the hospital) attended the deceased from <b>January 1959</b> to <b>April 3, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1960</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph H. Cowan M.D.</b>		22b. DATE SIGNED <b>April 4, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joseph h. cowan</b>		22d. ADDRESS <b>4817 Lenoxan Av. N.W. Wash DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		23b. DATE THEREOF <b>4/6/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>NORTH JACKSON CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>MAHONING COUNTY, OHIO</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>WAGNER E. PUMPHREY, INC.</b>		25a. REC'D BY REGISTRAR <b>APR 5 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

CERTIFICATE OF DEATH

1973

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Doctor

Signature of Registrar

Signature of Coroner

Signature of Medical Officer

Signature of Registrar

Signature of Coroner

Signature of Registrar

Signature of Coroner

4774

## CERTIFICATE OF DEATH

64689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>169 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>5 Dogwood Lane</b>			
3. NAME OF DECEASED (Type or print) First <b>Cornelia</b> Middle <b>Naomi</b> Last <b>Griffing</b>				4. DATE OF DEATH Month <b>April</b> Day <b>14</b> , Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 4, 1927</b>		9. AGE (In years last birthday) yrs. <b>32</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Merlo</b>				14. MOTHER'S MAIDEN NAME <b>Filomena Lamola</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive gastrointestinal hemorrhage</b> DUE TO <b>Acute lymphocytic leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>18 months</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 28, 1959</b> to <b>April 14, 1960</b> , that I last saw the deceased alive on <b>April 14, 1960</b> , and that death occurred at <b>4:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/14/60</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>Arthur R. Rothman, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Arthur R. Rothman, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>4/14/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillside Cemetery</b>		22d. LOCATION (City, town, or county) <b>Wood Ridge, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarring</b>				24a. REC'D BY REGISTRAR DATE <b>APR 20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2004-2005

Figure 1. Schematic diagram of the experimental setup.

3 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 10

• **1990** – **1991** – **1992** – **1993** – **1994** – **1995** – **1996** – **1997** – **1998** – **1999** – **2000** – **2001** – **2002** – **2003** – **2004** – **2005** – **2006** – **2007** – **2008** – **2009** – **2010** – **2011** – **2012** – **2013** – **2014** – **2015** – **2016** – **2017** – **2018** – **2019** – **2020** – **2021** – **2022** – **2023** – **2024** – **2025** – **2026** – **2027** – **2028** – **2029** – **2030** – **2031** – **2032** – **2033** – **2034** – **2035** – **2036** – **2037** – **2038** – **2039** – **2040** – **2041** – **2042** – **2043** – **2044** – **2045** – **2046** – **2047** – **2048** – **2049** – **2050** – **2051** – **2052** – **2053** – **2054** – **2055** – **2056** – **2057** – **2058** – **2059** – **2060** – **2061** – **2062** – **2063** – **2064** – **2065** – **2066** – **2067** – **2068** – **2069** – **2070** – **2071** – **2072** – **2073** – **2074** – **2075** – **2076** – **2077** – **2078** – **2079** – **2080** – **2081** – **2082** – **2083** – **2084** – **2085** – **2086** – **2087** – **2088** – **2089** – **2090** – **2091** – **2092** – **2093** – **2094** – **2095** – **2096** – **2097** – **2098** – **2099** – **2100** – **2101** – **2102** – **2103** – **2104** – **2105** – **2106** – **2107** – **2108** – **2109** – **2110** – **2111** – **2112** – **2113** – **2114** – **2115** – **2116** – **2117** – **2118** – **2119** – **2120** – **2121** – **2122** – **2123** – **2124** – **2125** – **2126** – **2127** – **2128** – **2129** – **2130** – **2131** – **2132** – **2133** – **2134** – **2135** – **2136** – **2137** – **2138** – **2139** – **2140** – **2141** – **2142** – **2143** – **2144** – **2145** – **2146** – **2147** – **2148** – **2149** – **2150** – **2151** – **2152** – **2153** – **2154** – **2155** – **2156** – **2157** – **2158** – **2159** – **2160** – **2161** – **2162** – **2163** – **2164** – **2165** – **2166** – **2167** – **2168** – **2169** – **2170** – **2171** – **2172** – **2173** – **2174** – **2175** – **2176** – **2177** – **2178** – **2179** – **2180** – **2181** – **2182** – **2183** – **2184** – **2185** – **2186** – **2187** – **2188** – **2189** – **2190** – **2191** – **2192** – **2193** – **2194** – **2195** – **2196** – **2197** – **2198** – **2199** – **2200** – **2201** – **2202** – **2203** – **2204** – **2205** – **2206** – **2207** – **2208** – **2209** – **2210** – **2211** – **2212** – **2213** – **2214** – **2215** – **2216** – **2217** – **2218** – **2219** – **2220** – **2221** – **2222** – **2223** – **2224** – **2225** – **2226** – **2227** – **2228** – **2229** – **2230** – **2231** – **2232** – **2233** – **2234** – **2235** – **2236** – **2237** – **2238** – **2239** – **2240** – **2241** – **2242** – **2243** – **2244** – **2245** – **2246** – **2247** – **2248** – **2249** – **2250** – **2251** – **2252** – **2253** – **2254** – **2255** – **2256** – **2257** – **2258** – **2259** – **2260** – **2261** – **2262** – **2263** – **2264** – **2265** – **2266** – **2267** – **2268** – **2269** – **2270** – **2271** – **2272** – **2273** – **2274** – **2275** – **2276** – **2277** – **2278** – **2279** – **2280** – **2281** – **2282** – **2283** – **2284** – **2285** – **2286** – **2287** – **2288** – **2289** – **2290** – **2291** – **2292** – **2293** – **2294** – **2295** – **2296** – **2297** – **2298** – **2299** – **2300** – **2301** – **2302** – **2303** – **2304** – **2305** – **2306** – **2307** – **2308** – **2309** – **2310** – **2311** – **2312** – **2313** – **2314** – **2315** – **2316** – **2317** – **2318** – **2319** – **2320** – **2321** – **2322** – **2323** – **2324** – **2325** – **2326** – **2327** – **2328** – **2329** – **2330** – **2331** – **2332** – **2333** – **2334** – **2335** – **2336** – **2337** – **2338** – **2339** – **2340** – **2341** – **2342** – **2343** – **2344** – **2345** – **2346** – **2347** – **2348** – **2349** – **2350** – **2351** – **2352** – **2353** – **2354** – **2355** – **2356** – **2357** – **2358** – **2359** – **2360** – **2361** – <

4775

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 days</u> <u>48</u> <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4903 Battery Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Victor Grubbs</u>				4. DATE OF DEATH Month Day Year <u>April 20 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-18-69</u>	
9. AGE (in years lost birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ind. Limestone Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Grubbs</u>				14. MOTHER'S MAIDEN NAME <u>Estherith Steele</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>		INFORMANT <u>Mrs. S.W. Galbuly</u> Address <u>4903 Battery Lane Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>444X</u> IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension &amp; Atherosclerosis</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 38</u> , 19 <u>58</u> , to <u>4-20-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-20-60</u> , 19 <u>60</u> , and that death occurred at <u>6:05 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul D. Cantor</u> M.D.				ADDRESS (Street, city or town, state) <u>4709 Montgomery Lane Bethesda, Maryland</u>		DATE SIGNED <u>4-21-60</u>	
PHYSICIAN'S NAME (Type) <u>PAUL D. CANTOR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-22-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Orlino S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1775

CERTIFICATE OF DEATH

1

1

4-21-00

4000

PAUL D. CANNON

SEATTLE, WASH.

4-23-00

4-23-00

4-23-00

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4776

## CERTIFICATE OF DEATH

64691

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Mont. Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>51 Chevy Chase</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Dukurban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Elmer</i> Middle <i>Leroy</i> Last <i>Hall</i>		DATE OF DEATH Month <i>April</i> Day <i>2</i> Year <i>1960</i>	
5. SEX <i>m.</i>	6. COLOR OR RACE <i>w</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/20/93</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Diamond Dr. Co.</i>	
11. BIRTHPLACE (State or foreign country) <i>Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Elmer Leroy Hall</i>		14. MOTHER'S MAIDEN NAME <i>Harriet Adams</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>1918</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction - Antero septal</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Thrombosis</i> DUE TO (c) <i>Coronary atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 Days</i> <i>7 Days</i> <i>Unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour <i>4:30</i> p. m. 19 <i>60</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1950, to <i>April 2</i> , 1960, that I last saw the deceased alive on <i>April 2</i> , 1960, and that death occurred at <i>10:44</i> p.m., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Stewart Clapp</i>		ADDRESS (Street, city or town, state) <i>3921 Ingomar St. N.W. Wash 15 D.C.</i>	
PHYSICIAN'S NAME (Type) <i>Stewart Clapp</i>		DATE SIGNED <i>4.3.60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4/5/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Rockville, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
24a. REC'D BY REGISTRAR DATE <i>APR 7 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4777

## CERTIFICATE OF DEATH

64692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>1101 7th Street, SE</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Dora</b> Last <b>Haskins</b>				4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 19, 1901</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>		IF UNDER 24 HRS. Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeping</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Charles H. Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Mary Dyson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>Unascertainable</b>			
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Right Cerebral Infarct</b> 467.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Vascular Occlusion</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 30</b> , 19 <b>60</b> , to <b>April 4</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 4</b> , 19 <b>60</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>April 5, 1960</b> ACTUAL SIGNATURE <b>Paul H. Altrocchi</b> M.D. <b>The Clinical Center</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland PHYSICIAN'S NAME (Type) <b>Paul H. Altrocchi, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>4-9-60</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>							
22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Alex S. Pope, Jr.</b> ADDRESS <b>414-15th St., S.E.</b> DATE <b>APR 7 '60</b> REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Ministry of Health

England

Warrington

2 days

1914

121, 123 Street, 12

121, 123 Street, 12

Warrington

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

Ministry of Health

England

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

121, 123 Street, 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1  
M  
074  
I  
D  
1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4778  
CERTIFICATE OF DEATH

64693  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lucie</b> Middle <b>C</b> Last <b>Hauser</b>		4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1894</b>
9. AGE (In years lost birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unobtainable</b>		14. MOTHER'S MAIDEN NAME <b>Unobtainable</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>	
INFORMANT (Nephew) <b>John F. Hauser, Jr.</b>		Address <b>5514 Lincoln St. Bethesda, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Emboli</b> 463X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-phlebitis left leg.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>3 weeks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cardiac decompensation</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 4, 1940</b> to <b>April 14, 1960</b> , that I last saw the deceased alive on <b>April 13, 1960</b> , and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED.	
ACTUAL SIGNATURE <b>W.B. Wardrop, M.D.</b>		M.D. <b>800 Pershing Drive Bethesda, Md. April 14, 1960</b>	
PHYSICIAN'S NAME (Type) <b>W.B. Wardrop, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/16/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Jones Co</b>		ADDRESS <b>2901-14th St. N.W.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Jones</b>	



# CERTIFICATE OF DEATH

1918

2

RECEIVED  
MAY 11 1918  
U.S. DEPT. OF HEALTH  
BUREAU OF VITAL STATISTICS

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Place of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Date of registration</p>		<p>12. Place of registration</p>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64694

4692 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>2nd</u> b. COUNTY <u>Pr. Georges</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park.</u>		c. LENGTH OF STAY IN 1b <u>2 days.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi 2nd</u> <u>1673.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium Hospital</u>		d. STREET ADDRESS <u>10529 Edgewood Dr</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BBBY GIRL HEMKIN</u>		4. DATE OF DEATH Month Day Year <u>4 25 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-1960</u>
9. AGE (In years lost birthday) <u>—</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>2 3 1/4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Roger Wayne Hemken</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Showacre</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Records.</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYALINE MEMBRANE DISEASE</u> <u>773.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>LIFE</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>ATELECTASIS, FOETAL</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/23</u> 19 <u>60</u> to <u>1/24</u> 19 <u>60</u> , that I last saw the deceased alive on <u>1/23</u> 19 <u>60</u> , and that death occurred at <u>145A</u> PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Joseph J. McDonald</u> M.D.		<u>7309 Riggs Rd.</u> <u>W. Hyattsville, Md.</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4-26-60</u>	<u>Cedar Hill</u>	<u>Suitland 2nd</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>4812 Riggs Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 3 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION



4779

CERTIFICATE OF DEATH

Reg. Dist. No. 4695

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>			
c. LENGTH OF STAY IN 1b <b>10 days</b>				<b>24</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>8028 Piney Branch Rd.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha Wells Henderson</b>				4. DATE OF DEATH Month Day Year <b>April 27 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 24, 1980</b>	
9. AGE (In years lost birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Oregon</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Thomas Benton Wells</b>				14. MOTHER'S MAIDEN NAME <b>Julia Benson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Dorothy Heilman</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> (c) <b>Myxedema</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 d</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myxedema</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 26, 1959</b> , to <b>27 April, 1960</b> , that I last saw the deceased alive on <b>26 April, 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10511 Summit Ave. Penn. Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Horace W. Benton, M.D.</b>				PHYSICIAN'S NAME (Type) <b>HORACE W. BERTON</b>			
22a. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) <b>TRANS. &amp; BURIAL 5/2/60</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Olney Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pendleton, Oregon</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PIMPHREY, INC.</b> <b>Raymond A. Paska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24e. REC'D BY REGISTRAR DATE <b>APR 29 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name

Age

Sex

Marital Status

Place of Birth

Date of Birth

Place of Death

Time of Death

Cause of Death

Occupation

Education

Religion

Signature of Physician

Signature of Registrar

Signature of Witness

Date

Place

County

State

City

Signature of Registrar

Signature of Witness

Date

Place

State

City

County

Signature of Registrar

Signature of Witness

Date

Place

State

City

County

Signature of Registrar

Signature of Witness

Date

Place

State

City

County

Signature of Registrar

Signature of Witness

Date

Place

State

City

County

Signature of Registrar

Signature of Witness

4780

## CERTIFICATE OF DEATH

64696

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>23</u> <u>das.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>H.</u> Last <u>Hooker</u>				4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/13/78</u>	
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Chestertown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Colin Ferguson Stam</u>				14. MOTHER'S MAIDEN NAME <u>Annie Harding Roberts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
INFORMANT (son) <u>Richard S. Hooker, 7730 Old Chester Rd., Beth, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO <u>692.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Gluteal Abscess perforating into peritoneal cavity</u> (c) <u>peritoneal cavity</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic pyelonephritis &amp; ulcerative cystitis</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part IV of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Bethesda, Md.</u>				20g. (County) <u>Montgomery</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Jan 1, 1960</u> , to <u>April 4, 1960</u> , that I last saw the deceased alive on <u>April 4, 1960</u> , and that death occurred at <u>10:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr Joseph Kenrick</u>				DATE SIGNED <u>4/4/60</u>			
PHYSICIAN'S NAME (Type) <u>Jos. P. Kenrick, M. D.</u>				ADDRESS (Street, city or town, state) <u>6450 Wisconsin Ave, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1280

CERTIFICATE OF DEATH

STATE OF

MASSACHUSETTS

DECEASED

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Age at Death

Sex

Color

Marital Status

Occupation

Education

Religion

Place of Birth

Country of Birth

Parents' Names

Signature of Registrar

Signature of Physician

Signature of Coroner

Signature of Minister

Signature of Justice

Signature of Notary

Signature of Witness

Signature of Family

Signature of Friend

Signature of Neighbor

Signature of Stranger

Signature of Other

Signature of Unknown

Signature of No One

Signature of All

Signature of Some

Signature of Many

Signature of Few

Signature of One

Signature of Two

Signature of Three

Signature of Four

Signature of Five

Signature of Six

Signature of Seven

Signature of Eight

Signature of Nine

Signature of Ten

Signature of Eleven

Signature of Twelve

Signature of Thirteen

Signature of Fourteen

Signature of Fifteen

Signature of Sixteen

Signature of Seventeen

Signature of Eighteen

Signature of Nineteen

Signature of Twenty

Signature of Twenty-One

Signature of Twenty-Two

Signature of Twenty-Three

Signature of Twenty-Four

Signature of Twenty-Five

Signature of Twenty-Six

Signature of Twenty-Seven

Signature of Twenty-Eight

Signature of Twenty-Nine

Signature of Thirty

Signature of Thirty-One

Signature of Thirty-Two

Signature of Thirty-Three

Signature of Thirty-Four

Signature of Thirty-Five

Signature of Thirty-Six

Signature of Thirty-Seven

Signature of Thirty-Eight

Signature of Thirty-Nine

Signature of Forty

Signature of Forty-One

Signature of Forty-Two

Signature of Forty-Three

Signature of Forty-Four

Signature of Forty-Five

Signature of Forty-Six

Signature of Forty-Seven

Signature of Forty-Eight

Signature of Forty-Nine

Signature of Fifty

Signature of Fifty-One

Signature of Fifty-Two

Signature of Fifty-Three

Signature of Fifty-Four

Signature of Fifty-Five

Signature of Fifty-Six

Signature of Fifty-Seven

Signature of Fifty-Eight

Signature of Fifty-Nine

Signature of Sixty

Signature of Sixty-One

Signature of Sixty-Two

Signature of Sixty-Three

Signature of Sixty-Four

Signature of Sixty-Five

Signature of Sixty-Six

Signature of Sixty-Seven

Signature of Sixty-Eight

Signature of Sixty-Nine

Signature of Seventy

Signature of Seventy-One

Signature of Seventy-Two

Signature of Seventy-Three

Signature of Seventy-Four

Signature of Seventy-Five

Signature of Seventy-Six

Signature of Seventy-Seven

Signature of Seventy-Eight

Signature of Seventy-Nine

Signature of Eighty

Signature of Eighty-One

Signature of Eighty-Two

Signature of Eighty-Three

Signature of Eighty-Four

Signature of Eighty-Five

Signature of Eighty-Six

Signature of Eighty-Seven

Signature of Eighty-Eight

Signature of Eighty-Nine

Signature of Ninety

Signature of Ninety-One

Signature of Ninety-Two

Signature of Ninety-Three

Signature of Ninety-Four

Signature of Ninety-Five

Signature of Ninety-Six

Signature of Ninety-Seven

Signature of Ninety-Eight

Signature of Ninety-Nine

Signature of One Hundred

Signature of One Hundred and One

Signature of One Hundred and Two

Signature of One Hundred and Three

Signature of One Hundred and Four

Signature of One Hundred and Five

Signature of One Hundred and Six

Signature of One Hundred and Seven

Signature of One Hundred and Eight

Signature of One Hundred and Nine

Signature of One Hundred and Ten

Signature of One Hundred and Eleven

Signature of One Hundred and Twelve

Signature of One Hundred and Thirteen

Signature of One Hundred and Fourteen

Signature of One Hundred and Fifteen

Signature of One Hundred and Sixteen

Signature of One Hundred and Seventeen

Signature of One Hundred and Eighteen

Signature of One Hundred and Nineteen

Signature of One Hundred and Twenty

Signature of One Hundred and Twenty-One

Signature of One Hundred and Twenty-Two

Signature of One Hundred and Twenty-Three

Signature of One Hundred and Twenty-Four

Signature of One Hundred and Twenty-Five

Signature of One Hundred and Twenty-Six

Signature of One Hundred and Twenty-Seven

Signature of One Hundred and Twenty-Eight

Signature of One Hundred and Twenty-Nine

Signature of One Hundred and Thirty

Signature of One Hundred and Thirty-One

Signature of One Hundred and Thirty-Two

Signature of One Hundred and Thirty-Three

Signature of One Hundred and Thirty-Four

Signature of One Hundred and Thirty-Five

Signature of One Hundred and Thirty-Six

Signature of One Hundred and Thirty-Seven

Signature of One Hundred and Thirty-Eight

Signature of One Hundred and Thirty-Nine

Signature of One Hundred and Forty

Signature of One Hundred and Forty-One

Signature of One Hundred and Forty-Two

Signature of One Hundred and Forty-Three

Signature of One Hundred and Forty-Four

Signature of One Hundred and Forty-Five

Signature of One Hundred and Forty-Six

Signature of One Hundred and Forty-Seven

Signature of One Hundred and Forty-Eight

Signature of One Hundred and Forty-Nine

Signature of One Hundred and Fifty

Signature of One Hundred and Fifty-One

Signature of One Hundred and Fifty-Two

Signature of One Hundred and Fifty-Three

Signature of One Hundred and Fifty-Four

Signature of One Hundred and Fifty-Five

Signature of One Hundred and Fifty-Six

Signature of One Hundred and Fifty-Seven

Signature of One Hundred and Fifty-Eight

Signature of One Hundred and Fifty-Nine

Signature of One Hundred and Sixty

Signature of One Hundred and Sixty-One

Signature of One Hundred and Sixty-Two

Signature of One Hundred and Sixty-Three

Signature of One Hundred and Sixty-Four

Signature of One Hundred and Sixty-Five

Signature of One Hundred and Sixty-Six

Signature of One Hundred and Sixty-Seven

Signature of One Hundred and Sixty-Eight

Signature of One Hundred and Sixty-Nine

Signature of One Hundred and Seventy

Signature of One Hundred and Seventy-One

Signature of One Hundred and Seventy-Two

Signature of One Hundred and Seventy-Three

Signature of One Hundred and Seventy-Four

Signature of One Hundred and Seventy-Five

Signature of One Hundred and Seventy-Six

Signature of One Hundred and Seventy-Seven

Signature of One Hundred and Seventy-Eight

Signature of One Hundred and Seventy-Nine

Signature of One Hundred and Eighty

Signature of One Hundred and Eighty-One

Signature of One Hundred and Eighty-Two

Signature of One Hundred and Eighty-Three

Signature of One Hundred and Eighty-Four

Signature of One Hundred and Eighty-Five

Signature of One Hundred and Eighty-Six

Signature of One Hundred and Eighty-Seven

Signature of One Hundred and Eighty-Eight

Signature of One Hundred and Eighty-Nine

Signature of One Hundred and Ninety

Signature of One Hundred and Ninety-One

Signature of One Hundred and Ninety-Two

Signature of One Hundred and Ninety-Three

Signature of One Hundred and Ninety-Four

Signature of One Hundred and Ninety-Five

Signature of One Hundred and Ninety-Six

Signature of One Hundred and Ninety-Seven

Signature of One Hundred and Ninety-Eight

Signature of One Hundred and Ninety-Nine

Signature of Two Hundred

Signature of Two Hundred and One

Signature of Two Hundred and Two

Signature of Two Hundred and Three

Signature of Two Hundred and Four

Signature of Two Hundred and Five

Signature of Two Hundred and Six

Signature of Two Hundred and Seven

Signature of Two Hundred and Eight

Signature of Two Hundred and Nine

Signature of Two Hundred and Ten

Signature of Two Hundred and Eleven

Signature of Two Hundred and Twelve

Signature of Two Hundred and Thirteen

Signature of Two Hundred and Fourteen

Signature of Two Hundred and Fifteen

Signature of Two Hundred and Sixteen

Signature of Two Hundred and Seventeen

Signature of Two Hundred and Eighteen

Signature of Two Hundred and Nineteen

Signature of Two Hundred and Twenty

Signature of Two Hundred and Twenty-One

Signature of Two Hundred and Twenty-Two

Signature of Two Hundred and Twenty-Three

Signature of Two Hundred and Twenty-Four

Signature of Two Hundred and Twenty-Five

Signature of Two Hundred and Twenty-Six

Signature of Two Hundred and Twenty-Seven

Signature of Two Hundred and Twenty-Eight

Signature of Two Hundred and Twenty-Nine

Signature of Two Hundred and Thirty

Signature of Two Hundred and Thirty-One

Signature of Two Hundred and Thirty-Two

Signature of Two Hundred and Thirty-Three

Signature of Two Hundred and Thirty-Four

Signature of Two Hundred and Thirty-Five

Signature of Two Hundred and Thirty-Six

Signature of Two Hundred and Thirty-Seven

Signature of Two Hundred and Thirty-Eight

Signature of Two Hundred and Thirty-Nine

Signature of Two Hundred and Forty

Signature of Two Hundred and Forty-One

Signature of Two Hundred and Forty-Two

Signature of Two Hundred and Forty-Three

Signature of Two Hundred and Forty-Four

Signature of Two Hundred and Forty-Five

Signature of Two Hundred and Forty-Six

Signature of Two Hundred and Forty-Seven

Signature of Two Hundred and Forty-Eight

Signature of Two Hundred and Forty-Nine

Signature of Two Hundred and Fifty

Signature of Two Hundred and Fifty-One

Signature of Two Hundred and Fifty-Two

Signature of Two Hundred and Fifty-Three

Signature of Two Hundred and Fifty-Four

Signature of Two Hundred and Fifty-Five

Signature of Two Hundred and Fifty-Six

Signature of Two Hundred and Fifty-Seven

Signature of Two Hundred and Fifty-Eight

Signature of Two Hundred and Fifty-Nine

Signature of Two Hundred and Sixty

Signature of Two Hundred and Sixty-One

Signature of Two Hundred and Sixty-Two

Signature of Two Hundred and Sixty-Three

Signature of Two Hundred and Sixty-Four

Signature of Two Hundred and Sixty-Five

Signature of Two Hundred and Sixty-Six

Signature of Two Hundred and Sixty-Seven

Signature of Two Hundred and Sixty-Eight

Signature of Two Hundred and Sixty-Nine

Signature of Two Hundred and Seventy

Signature of Two Hundred and Seventy-One

Signature of Two Hundred and Seventy-Two

Signature of Two Hundred and Seventy-Three

Signature of Two Hundred and Seventy-Four

Signature of Two Hundred and Seventy-Five

Signature of Two Hundred and Seventy-Six

Signature of Two Hundred and Seventy-Seven

Signature of Two Hundred and Seventy-Eight

Signature of Two Hundred and Seventy-Nine

Signature of Two Hundred and Eighty

Signature of Two Hundred and Eighty-One

Signature of Two Hundred and Eighty-Two

Signature of Two Hundred and Eighty-Three

Signature of Two Hundred and Eighty-Four

Signature of Two Hundred and Eighty-Five

Signature of Two Hundred and Eighty-Six

Signature of Two Hundred and Eighty-Seven

Signature of Two Hundred and Eighty-Eight

Signature of Two Hundred and Eighty-Nine

Signature of Two Hundred and Ninety

Signature of Two Hundred and Ninety-One

Signature of Two Hundred and Ninety-Two

Signature of Two Hundred and Ninety-Three

Signature of Two Hundred and Ninety-Four

Signature of Two Hundred and Ninety-Five

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in an event within 72 hours after death.

VS. AT5ME  
5M 7/59

1A  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4781 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

u4657

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Cal</u> b. COUNTY <u>Riverside</u> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Corona</u>	
c. LENGTH OF STAY in 1b <u>4 1/2 days</u>		d. STREET ADDRESS <u>825 Grand Blvd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>825 5th Johnson Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anthony Zenno Howard</u>		4. DATE OF DEATH <u>April 27 1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-13-1897</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Food business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Term.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John D. Howard</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Marshall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes WW 1</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Lulu Howard (wife)</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> end in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 4/29/60</u>		22b. DATE THEREOF <u>4-29-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crest Lawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Corona, California</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		24. REC'D BY REGISTRAR <u>APR 29 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>		24c. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	

1931

1-1  
1-2  
1-3  
1-4  
1-5  
1-6  
1-7  
1-8  
1-9  
1-10

*[Faint, mostly illegible text from the body of the certificate, including fields for name, age, sex, and cause of death.]*

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
M  
4693  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
4698

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>23 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium-Hospital</u>				d. STREET ADDRESS <u>2719 Randolph Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marjorie Marie Howell</u>				4. DATE OF DEATH Month Day Year <u>April 17 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 July 1921</u>	
9. AGE (In years lost birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Frederick Bush</u>				14. MOTHER'S MAIDEN NAME <u>Sylvia Cramer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>166-186-698</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized peritonitis</u> <u>578X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Perforation 2 colon</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>3 wk</u> <u>3 wk</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>3-26 1960</u> to <u>4-17 1960</u> , that (I) (we) last saw the deceased alive on <u>4-16 1960</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>A.W. Danish</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-17-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.W. DANISH</u>				22d. ADDRESS <u>927 PERSHING DR</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/19/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 19 1960</u>	
25b. REGISTRAR'S SIGNATURE <u>Carlton S. Knepp</u>							

578x

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4782 CERTIFICATE OF DEATH 04699

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MONTGOMERY COUNTY GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>Rt. 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SPENCER CLEVELAND HOWES</u>				4. DATE OF DEATH Month Day Year <u>APRIL 26 1960</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/1884</u>		9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same as 10a</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN HOWES</u>				14. MOTHER'S MAIDEN NAME <u>HELEN M. GAITHER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT <u>HOSPITAL RECORDS, OLNEY, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemi plegia, left. &amp; Pyrexia</u> DUE TO (b) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>4/23 60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>4/26 60</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>4/23 60</u> to <u>4/26 60</u> , that (I) (we) last saw the deceased alive on <u>4/26 60</u> , and that death occurred at <u>3:15 PM</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <u>3:15 PM</u>		22b. DATE SIGNED <u>4/27/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. H. LIGON, M. D.</u>				22d. ADDRESS <u>SANDY SPRING, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-29-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		23d. LOCATION (City, town, or county) (State) <u>Sunshine, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 29 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



5-20

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 4715 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64760

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>7 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>07 Gaithersburg</u>		d. STREET ADDRESS <u>14 Park Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>14 Park Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Carroll</u> Last <u>Howes</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-1885</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>James R. Howes</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Green</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>George W. Howes, Rt. #2 Gaithersburg MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>Small deep infarct</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bluschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Bluschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>4-17-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 19, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Neelsville Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Neelsville, Md.</u>	
23. FUNERAL DIRECTOR <u>Francis H. Barber</u>				24a. REC'D BY REGISTRAR <u>APR 20 '60</u>			
ADDRESS <u>Laytonsville, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

THE STATE

OF NEW YORK

IN SENATE

1911

REPORT OF THE  
COMMISSIONER OF THE  
DEPARTMENT OF  
CORRECTIONS  
FOR THE YEAR  
1910

1  
4783  
MONTGOMERY COUNTY  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
64701

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>2 HR. 31 MIN.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> d. STREET ADDRESS <b>Rt. #97</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>HUNGERFORD</b> Last <b>HUNGERFORD</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>19 60</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/25/60</b>
9. AGE (In years last birthday) yrs. <b>2</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>31</b> Hours <b>31</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11c. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		11d. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>LILLIAN BEATRICE HUNGERFORD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity - 5 months gestation</b> DUE TO (b) <b>Birth wt. - 1 lb. 6 oz.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>No prenatal care.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 25 1960</b> to <b>APRIL 25 1960</b> , that (I) (we) last saw the deceased alive on <b>APRIL 25 1960</b> , and that death occurred <b>5:35AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>W. A. Linthicum</b> M.D.		22b. DATE SIGNED <b>4/25/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. A. LINTHICUM, M. D.</b>		22d. ADDRESS <b>ROCKVILLE, Md.</b>	
23a. BURIAL, CREMATION, REMAINS (Type) <b>Buried</b>		23b. DATE THEREOF <b>4/26/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Gates of Heaven</b>		23d. LOCATION (City, town, or county) (State) <b>Aspen Hill, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Furman</b> ADDRESS <b>Rockville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 28 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>			

2073192XV0

CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

1

4784

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>54 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>29 Silver Spring</u>			
				f. STREET ADDRESS <u>1221 Dale Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H</u> Last <u>Hunter</u>				4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/9/79</u>	9. AGE (In years lost birthday) yrs. <u>80</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trust</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas Hunter</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Pearce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-36-1834</u>		INFORMANT <u>Daughter (Mrs. Gertrude M o Rorie)</u> Address <u>1221 Dale Drive, Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> (Symptoms) <u>four months</u> 334 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> Unknown DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1, 1954</u> to <u>April 1, 1960</u> , that I last saw the deceased alive on <u>March 31, 1960</u> , and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u>				ADDRESS (Street, city or town, state) <u>8237 Georgia Ave Silver Spring, Md</u> DATE SIGNED <u>April 1, 1960</u>			
PHYSICIAN'S NAME (Type) <u>Aaron Traum M.D</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/4/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Glen, Montgomery Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 4 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



30 days

Western

from

from from

Thomas Hunter

1911-1912

1911-1912

## 4785 CERTIFICATE OF DEATH

64703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>34 Wheaton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>12116 Halewood Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Girl</b>				4. DATE OF DEATH <b>April 16 1960</b>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/16/60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William W. Huss</b>				14. MOTHER'S MAIDEN NAME <b>Gloria Ferguson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PREMATURITY - 15 WEEKS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>PREMATURE LABOR - RUPTURED MEMBRANES</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-16</b> , 19 <b>60</b> , to <b>4-16</b> , 19 <b>60</b> that I last saw the deceased alive on <b>4-16</b> , 19 <b>60</b> , and that death occurred at <b>7:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Robert A. Warthen</b> M.D.				PHYSICIAN'S NAME (Type) <b>ROBERT A WARTHEN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>CREMATION</b>		<b>4-18-60</b>		<b>Suburban Hospital</b>		<b>8600 Old Georgetown Rd Bethesda Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suburban Hospital 8600 O'Georgetown Rd Maryland</b>				24a. REC'D BY REGISTRAR <b>APR 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

Northampton County

Northampton Hospital

Baby Girl

Female

William W. Gloria Ferguson

Hospital Record

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4729

## CERTIFICATE OF DEATH

04764

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. LENGTH OF STAY IN 1b <b>33</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4420 Aspen Hill Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Forrest</b> Middle <b>R.</b> Last <b>Jackson</b>				4. DATE OF DEATH Month <b>Apr.</b> Day <b>16,</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1899</b> <b>October 26,</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>20</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Accounting</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>John W. Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Annie R. Runbel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-03-5441</b>		17. INFORMANT Address <b>William L. Jackson-brother-same as 2d</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary emphysema</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <b>2/12</b> 19 <b>60</b> to <b>2/16</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>2/8</b> 19 <b>60</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>John W. Latimer</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>John W. Latimer</b>				22d. ADDRESS <b>1728 Mass. Ave., N.W., Washington, DC</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/21/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pennsburg Church Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Red Hill, Pennsylvania</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>APR 19 1960</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF DEATH

1928

DECEASED

ROCHESTER

4430 Apple Hill Road

ROCHESTER

WHITE

ACCOUNTING

JOHN J. JACOB

27-12-24

ROCHESTER - NEW YORK

MASSACHUSETTS DEPARTMENT OF CORRECTIONS  
CERTIFICATE OF DEATH  
1928  
DECEASED  
ROCHESTER  
4430 Apple Hill Road  
ROCHESTER  
WHITE  
ACCOUNTING  
JOHN J. JACOB  
27-12-24  
ROCHESTER - NEW YORK  
MASSACHUSETTS DEPARTMENT OF CORRECTIONS  
CERTIFICATE OF DEATH  
1928  
DECEASED  
ROCHESTER  
4430 Apple Hill Road  
ROCHESTER  
WHITE  
ACCOUNTING  
JOHN J. JACOB  
27-12-24  
ROCHESTER - NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G261 4/28/60 iwk

4666

CERTIFICATE OF DEATH

Reg. Dist. 205

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>McLean</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McLean</u> 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mary Lee Nursing Home</u>		d. STREET ADDRESS <u>1608 Tucker Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>W</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 17 1865</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamist Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas D Divine</u>		14. MOTHER'S MAIDEN NAME <u>Emily Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Roy T Payne Sr</u>		Address <u>1608 Tucker Ave McLean Va</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>422.2</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocardial disease</u> DUE TO <u>2 years</u> (c) <u>Tenaculous arteriosclerosis</u> DUE TO <u>2 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-20</u> , 19 <u>59</u> to <u>4-20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-15</u> , 19 <u>60</u> , and that death occurred at <u>3:45</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S Rogers</u> M.D.		ADDRESS (Street, city or town, state) <u>1919 Seminary Pl. Silver Spring Md</u> DATE SIGNED <u>4-20-60</u>	
PHYSICIAN'S NAME (Type) <u>John S Rogers</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-23-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Wisc Ave Wash D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u> ADDRESS <u>3072 Mt St NW</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Howard</u> DATE <u>APR 22 '60</u>	
		24b. REGISTRAR'S SIGNATURE	



1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04706

4786

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rainway Hills</i>		c. LENGTH OF STAY IN 1b <i>5 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>59 Rainway Hills</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>6210-Crathis Lane</i>			d. STREET ADDRESS <i>6210-Crathis Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>NORA</i> Middle <i>JOHNSON</i> Last <i>JOHNSON</i>			4. DATE OF DEATH Month <i>4</i> - Day <i>1</i> - Year <i>1960</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-5-73</i>	9. AGE (In years last birthday) <i>86</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State, or foreign country) <i>Indiana</i>	
13. FATHER'S NAME <i>William H. Harrison</i>			14. MOTHER'S MAIDEN NAME <i>Mary E. Bradford</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>418-38-1234</i>		17. INFORMANT <i>Mary K. Moody</i> Address <i>6210-Crathis Lane, Rainway Hills, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral arteriosclerosis</i> 334 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <i>Jan.</i> 1958, to <i>April 1,</i> 1960, that I last saw the deceased alive on <i>March 31,</i> 1960, and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>41160 DATE SIGNED</i> ACTUAL SIGNATURE <i>Walter K. Cingevine</i> M.D. <i>6300-13th St. N.W., Wash. D.C.</i> PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>4/1/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln</i>	22d. LOCATION (City, town, or county) (State) <i>Bladensburg, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers &amp; Co., Inc.</i> ADDRESS <i>3072-M. St. N.W.</i>			24a. REC'D BY REGISTRAR DATE <i>APR 4 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hunt</i>	

CERTIFICATE OF DEATH

4328

WILLIAM REID  
FINDING  
FINDING

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
WILLIAM REID		M		45		JAN 15 1900	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
BALTIMORE		MD		MD		USA	
OCCUPATION		PROFESSION		INDUSTRY		TRADE	
LABORER		LABORER		LABORER		LABORER	
CAUSE OF DEATH		IMMEDIATE		INTERMEDIATE		FINAL	
HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE	
NATURAL		NATURAL		NATURAL		NATURAL	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY	
JAN 15 1945		10:00 AM		BALTIMORE		MD	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 15 1945		JAN 15 1945		JAN 15 1945		JAN 15 1945	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

4787

64707

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. STATE <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>X</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>		d. STREET ADDRESS <b>ROUTE #1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GEN. HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WALKER</b> Middle <b>JAMES</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>22</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-26-1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>HARRIETT JOHNSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>HOSPITAL RECORDS</b>	
17. INFORMANT <b>OLNEY, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolism</b> DUE TO <b>Coronaria - Rupture</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>Intestinal Obstruction</b> (c) <b>See to b.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr. 20, 1960</b> to <b>Apr. 22, 1960</b> , that (I) (we) last saw the deceased alive on <b>Apr. 22, 1960</b> and that death occurred <b>Apr. 22, 1960</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Jack Schumacher</b> M.D.		22b. DATE <b>Apr. 23, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>JACK SCHUMACHER, M. D.</b>		22d. ADDRESS <b>GAITHERSBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/26/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Brooke Grove Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Laytonsville, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b> ADDRESS <b>Rookville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 26 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Knaus</b>			

178  
CERTIFICATE OF DEATH

1

1

4788

## CERTIFICATE OF DEATH

64708

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Rockville</b>			
c. LENGTH OF STAY IN 1b <b>6 Hrs.</b>				d. STREET ADDRESS <b>716 Brent Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ches ter A Jones</b>				4. DATE OF DEATH Month Day Year <b>April 8 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1, 1883</b>		9. AGE (In years lost birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumberman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Josiah Jones</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Burke</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT <b>Mrs. H.G. Hartman -daughter-same as 2d</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential Hypertension</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 Hours</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 1957</b> to <b>April 8 1960</b> , that I last saw the deceased alive on <b>April 7 1960</b> and that death occurred at <b>11:40 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William Frank</b>				M.D. <b>544 W. Montgomery Ave. Rockville</b> DATE SIGNED <b>4/8/60</b>			
PHYSICIAN'S NAME (Type) <b>William Frank</b>				544 W. Montg. Ave. Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/11/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>APR 11 1960</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

Dr. Brochart Notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF NEW YORK  
IN SENATE  
January 10, 1907.  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE  
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE  
MAY 1, 1906.  
ALBANY:  
J. B. LIPPINCOTT & COMPANY, PRINTERS.  
1907.

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Avlinton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium Hospital, Takoma Park Md.</u>				d. STREET ADDRESS <u>1415 N. Hudson St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u> First <u>Henry</u> Middle <u>JONES</u> Last				4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-17-88</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>minister</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sec. Treasurer of Conference Penna.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Jones (England)</u>				14. MOTHER'S MAIDEN NAME <u>Mary ? (unknown to Pt) (England)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of liver &amp; pancreas, mode to 16</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diagnosis: Ca of colon</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Spence for guidance &amp; retention</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>  </u> to <u>April 8, 1960</u> that I last saw the deceased alive on <u>April 7, 1960</u> , and that death occurred at <u>1:45 A.M.</u> from the causes and on the date stated above. <u>Edw H. Wolohin</u> ADDRESS (Street, city or town, state) <u>7600 Carroll Ave Takoma Park Md.</u> DATE SIGNED							
ACTUAL SIGNATURE				M.D.			
PHYSICIAN'S NAME (Type) <u>Chas H WOLOHIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 11 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith H. Wallers</u> ADDRESS <u>254 Carroll St NE DC</u>				24. REC'D BY REGISTRAR DATE <u>APR 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William E. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LS

4789

Item 22 Film G261 4/25/60 cap

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>18 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Ahoskie</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>70x-3</b> d. STREET ADDRESS <b>720 Everett Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Travis Jones</b>				4. DATE OF DEATH Month Day Year <b>April 18 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 21, 1938 21 yrs.</b>	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hugh T. Jones</b>				14. MOTHER'S MAIDEN NAME <b>Alice Markham</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>238-64-5959</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary emphysema and bronchiectasis</b> <b>587.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cystic fibrosis of the pancreas</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>21 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 31</b> , 19 <b>60</b> , to <b>April 18</b> , 19 <b>60</b> that I last saw the deceased alive on <b>April 18</b> , 19 <b>60</b> , and that death occurred at <b>12:00 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>4/18/60</b>							
ACTUAL SIGNATURE <b>George T. Bryan</b>				M.D. <b>The Clinical Center</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>GEORGE T. BRYAN, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/18/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>		22d. LOCATION (City, town, or county) (State) <b>Elizabeth City, N. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co., 2901 14th St. N.W.</b>				24a. REC'D BY REGISTRAR <b>Wash, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 4730 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 64711

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN lb <u>4 1/2 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1110 Maple Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frank J. Jowett</u>				4. DATE OF DEATH <u>Apr 26 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-5-1886</u>	
9. AGE (in years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>head writer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>			
11. BIRTHPLACE (State or foreign country) <u>Bradford England</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>John Broughton Jowett</u>				14. MOTHER'S MAIDEN NAME <u>Jane Wordley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-01-8562</u>			
17. INFORMANT <u>Arline Jowett</u>				Address <u>Stun 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hemorrhage</u> DUE TO <u>laceration of neck to right wrist</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Found dead in basement of home</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted razor lacerations</u>			
20c. TIME OF INJURY Month, Day, Year <u>7 p.m. 4-26 1960</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, store, office bldg., etc.) <u>Home</u>				20f. (City or town) <u>Rockville</u> (County) <u>Monty</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>4-26-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>4/29/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Math. Memo. Park</u>				22d. LOCATION (City, town, or country) <u>Falls Church Va</u>			
23. FUNERAL DIRECTOR <u>W.W. Chambers Co. 1400 Chapin St NW</u>				24a. REC'D BY REGISTRAR <u>APR 29 '60</u>			
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Kneale</u>			

MEDICAL CERTIFICATION



FOR THE  
OFFICE OF THE  
CHIEF OF MEDICAL SERVICE

1. The following information was obtained from the records of the  
Medical Department of the Army, Office of the Chief of Medical Service,  
Washington, D. C. 20315, on 10/10/71.  
2. The information was obtained from the records of the  
Medical Department of the Army, Office of the Chief of Medical Service,  
Washington, D. C. 20315, on 10/10/71.  
3. The information was obtained from the records of the  
Medical Department of the Army, Office of the Chief of Medical Service,  
Washington, D. C. 20315, on 10/10/71.  
4. The information was obtained from the records of the  
Medical Department of the Army, Office of the Chief of Medical Service,  
Washington, D. C. 20315, on 10/10/71.  
5. The information was obtained from the records of the  
Medical Department of the Army, Office of the Chief of Medical Service,  
Washington, D. C. 20315, on 10/10/71.  
6. The information was obtained from the records of the  
Medical Department of the Army, Office of the Chief of Medical Service,  
Washington, D. C. 20315, on 10/10/71.  
7. The information was obtained from the records of the  
Medical Department of the Army, Office of the Chief of Medical Service,  
Washington, D. C. 20315, on 10/10/71.  
8. The information was obtained from the records of the  
Medical Department of the Army, Office of the Chief of Medical Service,  
Washington, D. C. 20315, on 10/10/71.  
9. The information was obtained from the records of the  
Medical Department of the Army, Office of the Chief of Medical Service,  
Washington, D. C. 20315, on 10/10/71.  
10. The information was obtained from the records of the  
Medical Department of the Army, Office of the Chief of Medical Service,  
Washington, D. C. 20315, on 10/10/71.

1

4790

## CERTIFICATE OF DEATH

04712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Princess Anne</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norfolk</u> 83X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>117 Sedgemoor Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Deborah</u> Middle <u>Ann</u> Last <u>Keller</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 22, 1957</u>		9. AGE (In years lost birthday) <u>2</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Keller</u>				14. MOTHER'S MAIDEN NAME <u>Kate Walton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Radiation Fibrosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Wil'm's Tumor</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>4 months</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>April 8</u> , 19 <u>60</u> , to <u>April 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 24</u> , 19 <u>60</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Harold J. Fallon</u> M.D. <u>The Clinical Center</u> <u>April 25, 1960</u> PHYSICIAN'S NAME (Type) <u>HAROLD J. FALLON, M. D.</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>4/27/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Norfolk, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>APR 26 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: John Doe  
2. Sex: Male  
3. Age: 45  
4. Date of birth: 10/10/1920  
5. Place of birth: U.S.A.  
6. Date of death: 11/15/1965  
7. Place of death: U.S.A.  
8. Cause of death: Heart Disease  
9. Signature of physician: Dr. J. K. Smith  
10. Signature of registrar: John Doe

Richard F. Smith  
John Doe

11. Name of informant: John Doe  
12. Address of informant: 123 Main Street, U.S.A.  
13. Date of completion: 11/15/1965  
14. Signature of registrar: John Doe  
15. Signature of informant: John Doe

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05949

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>P. y.</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>D.O.A.</u>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring (Chargay Pk.)</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Squ. + Hosp</u>			d. STREET ADDRESS <u>8410 12th Ave 1657-2</u>		
3. NAME OF DECEASED (Type or print) <u>Baby Girl King</u>			4. DATE OF DEATH Month <u>Apr</u> Day <u>16</u> Year <u>1960</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-60</u>		9. AGE (In years last birthday) yrs. <u>0</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <u>Calvin John King</u>		
14. MOTHER'S MAIDEN NAME <u>Sallie Fitzgerald</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give year or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.0 anoxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>					
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Booschert</u>		M.D. <u>FRANK J. BOOSCHERT</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BOOSCHERT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4-16-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. San. &amp; Hospital</u>	
22d. LOCATION (City, town, or country) <u>Takoma Park Maryland</u>		22e. REC'D BY REGISTRAR DATE <u>MAY 20 '60</u>			
23. FUNERAL DIRECTOR <u>Robert A. Hare, M.D.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

5099VV VVVV



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4791

## CERTIFICATE OF DEATH

Reg. Dist. No.

64713

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b>				c. LENGTH OF STAY IN 1b <b>64 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>419 South Potomac Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jonathan</b> Middle <b>Calvin</b> Last <b>Knaub</b>				4. DATE OF DEATH Month <b>April</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 23, 1894</b>		9. AGE (In years last birthday) yrs. <b>65</b>	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Knaub</b>				14. MOTHER'S MAIDEN NAME <b>Ida Gasswint</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>716-09-9405</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO (b) <b>Lymphosarcoma of the stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Generalized atherosclerosis, severe</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 23, 1960</b> , to <b>April 26, 1960</b> , that I last saw the deceased alive on <b>April 26, 1960</b> , and that death occurred at <b>8:55 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center, Bethesda 14, Maryland</b> DATE SIGNED <b>4/27/60</b>							
ACTUAL SIGNATURE <b>Louis V. Avioli</b>		M.D. <b>The Clinical Center, Bethesda 14, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>Louis V. Avioli, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/30/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Chambersburg, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Enter-Rouzer Funeral Home</b> <b>B. Franklin Rye</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 2 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Knaub</b>			



# CERTIFICATE OF DEATH

1901

State of Illinois

DEPARTMENT OF HEALTH - CHICAGO, ILL.

<p>NAME OF DECEASED</p>		<p>AGE</p>		<p>SEX</p>		<p>RACE</p>		<p>DATE OF BIRTH</p>		<p>DATE OF DEATH</p>	
<p>RESIDENCE</p>		<p>PLACE OF BIRTH</p>		<p>EDUCATION</p>		<p>RELIGION</p>		<p>OCCUPATION</p>		<p>CAUSE OF DEATH</p>	
<p>DATE OF INTERMENT</p>		<p>PLACE OF INTERMENT</p>		<p>NAME OF FUNERAL HOME</p>		<p>NAME OF MINISTER</p>		<p>NAME OF CLERGYMAN</p>		<p>NAME OF SURGEON</p>	
<p>NAME OF PHYSICIAN</p>		<p>NAME OF NURSE</p>		<p>NAME OF ATTENDING CLERGYMAN</p>		<p>NAME OF FUNERAL HOME</p>		<p>NAME OF MINISTER</p>		<p>NAME OF CLERGYMAN</p>	
<p>NAME OF SURGEON</p>		<p>NAME OF NURSE</p>		<p>NAME OF ATTENDING CLERGYMAN</p>		<p>NAME OF FUNERAL HOME</p>		<p>NAME OF MINISTER</p>		<p>NAME OF CLERGYMAN</p>	

4719

## CERTIFICATE OF DEATH

Reg. Dist. No.

4714

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT LAUDERDALE</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens SAN.</b>				d. STREET ADDRESS <b>1733 S.W. 5<sup>th</sup> ST.</b>			
3. NAME OF DECEASED (Type or print) First <b>FANNIE</b> Middle <b>I.</b> Last <b>Leese</b>				4. DATE OF DEATH Month <b>4</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/18/1870</b>	
9. AGE (In years lost birthday) yrs. <b>90</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>18</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WM. SINCELL</b>				14. MOTHER'S MAIDEN NAME <b>MARY PROCTOR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>—</b>				16. SOCIAL SECURITY NO. <b>NONE</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis, generalized</b> DUE TO (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/78</b> , 19 <b>60</b> , to <b>4/5</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4/4</b> , 19 <b>60</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald Nelson</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>10620 Georgia Ave Silver Spg, Md 4/5/60</b>			
PHYSICIAN'S NAME (Type) <b>Donald Nelson, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APRIL 8/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H-yong Funeral Home - 1300 N St. NW</b>				ADDRESS <b>Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 7 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Clifton S. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1915

John Thomas  
1880 - 1915  
1125 1st St  
Wash D.C.

Mrs. John Thomas  
1125 1st St  
Wash D.C.

1915  
1125 1st St  
Wash D.C.  
Burial April 2/15  
1125 1st St  
Wash D.C.

4792

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. LENGTH OF STAY IN 1b <u>15 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MT. RAINIER</u> <u>1648 2</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>4603-25th St.</u>			
3. NAME OF DECEASED (Type or print) <u>LENA</u> First Middle Last				4. DATE OF DEATH <u>APRIL</u> Month Day Year <u>14</u> <u>1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>UNKNOWN</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Poland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>(UNKNOWN) LUKIN</u>				14. MOTHER'S MAIDEN NAME <u>? UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Years</u> (c) <u>—</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 59</u> to <u>Apr 3 60</u> , that I last saw the deceased alive on <u>4/17</u> , 19 <u>60</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jerome H. Epstein</u> M.D. <u>2025-Eye St, NW, Wash DC</u>				DATE SIGNED <u>APR 18 '60</u>			
PHYSICIAN'S NAME (Type) <u>JEROME H. EPSTEIN, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>MARYETH. P.I. N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwards Funeral Home</u> ADDRESS <u>4217-9th St NW</u>				24a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

M

090

TO HUSBAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64716

4793

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington, D.C.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Zion</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Russel Care Home</u>		d. STREET ADDRESS <u>640 Eye Street, S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Clinton</u> Middle <u>Lewis</u> Last <u>Lewis</u>		4. DATE OF DEATH Month <u>April</u> Day <u>14</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/8/1892</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>	IF UNDER 24 HRS. Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Fairfax, Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wesley Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Susie ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW-1</u>	
17. INFORMANT <u>Mrs. Elizabeth Lewis</u>		Address <u>640 Eye St; S.E. Wash; DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple CVA</u> DUE TO <u>Arteriosclerotic Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Hypertension</u> DUE TO <u>Hypertension</u> (b) <u>Hypertension</u> (c) <u>Hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-13</u> , 19 <u>60</u> , to <u>4-14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4-13</u> , 19 <u>60</u> , and that death occurred at <u>6:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clive E. Jackson</u> M.D.		ADDRESS (Street, city or town, state) <u>202 Martin Ln. Rockville Md.</u>	
PHYSICIAN'S NAME (Type) <u>Clive E. Jackson</u>		DATE SIGNED <u>4-14-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/19/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Stewart</u>		ADDRESS <u>30 H Street, N.E.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoms</u>	



443x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
4696  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
4717

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 da</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				d. STREET ADDRESS <u>1503 Sligo Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Douglas</u> Last <u>Howe</u>				4. DATE OF DEATH Month <u>4</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-24-84</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob N. Howe</u>				14. MOTHER'S MAIDEN NAME <u>Dora Louise</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Hosp Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO <u>Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteries</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>Undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thromboses (old) (multiple)</u> <u>Osteo-Arthritis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year <u>Hour a m</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While <u>  </u> Not while <u>  </u> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 7, 1951</u> to <u>Apr 7, 1960</u> , that (I) (we) last saw the deceased alive on <u>Apr 6, 1960</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>George L. Ball</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Apr 7, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>George L. Ball</u>				22d. ADDRESS <u>18670 Georgia Road Silver Spring Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/9/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Zicka</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>APR 11 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

1931

(A)

(1)

7

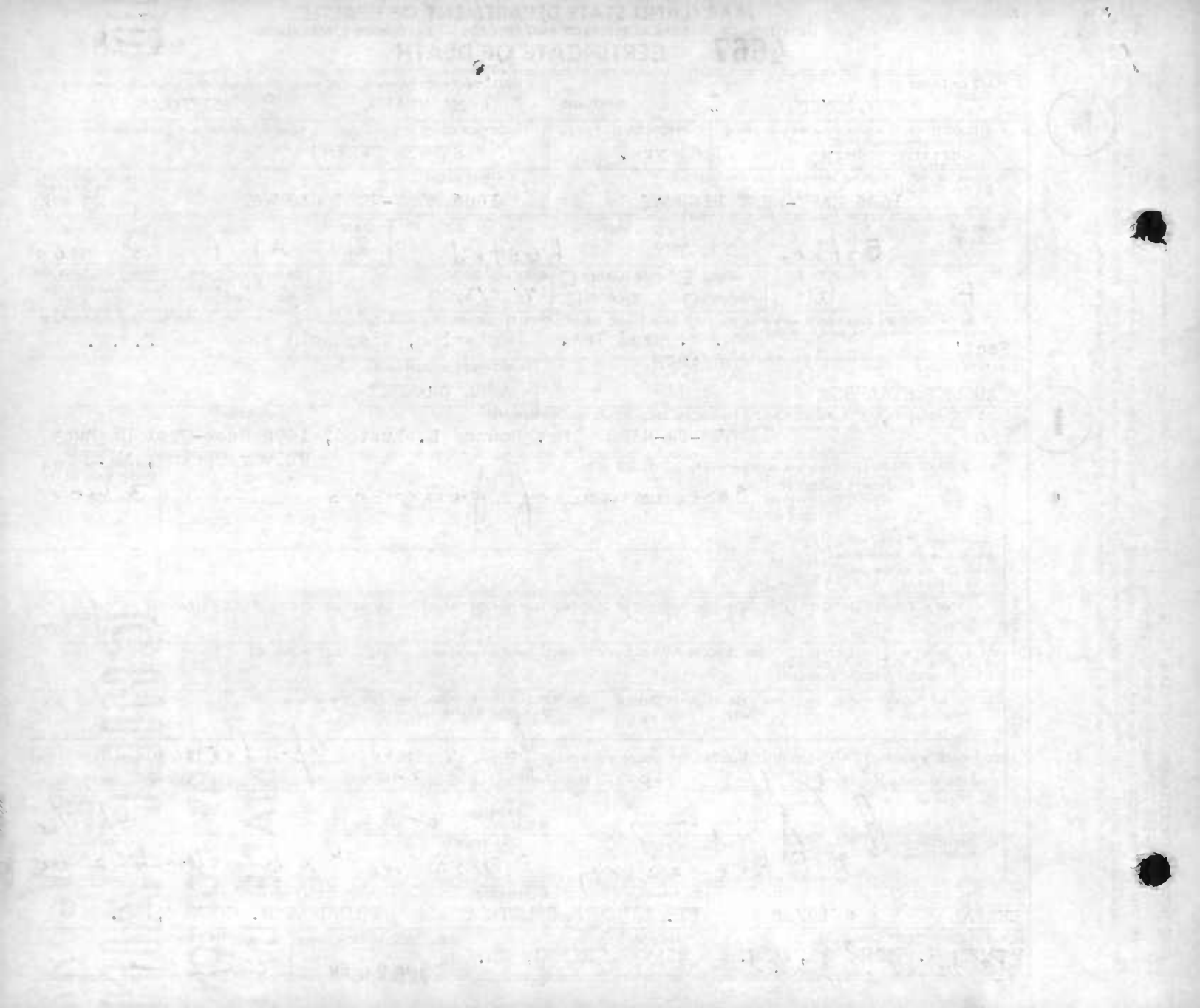
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
4  
M  
X  
I  
0  
1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4667 CERTIFICATE OF DEATH

04718

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1606 EAST-WEST HIGHWAY		1. d. STREET ADDRESS 1606 EAST-WEST HIGHWAY	
3. NAME OF DECEASED (Type or print) First Middle Last Esther DOROTHY Lusted		4. DATE OF DEATH Month Day Year April 15 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/28/1900
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sect'y		10b. KIND OF BUSINESS OR INDUSTRY Wm. T. Reed Ins. Agency	
11. BIRTHPLACE (State or foreign country) Waterloo, Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AUGUST STRAUSS		14. MOTHER'S MAIDEN NAME ANNA DRAEGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 578-24-4380	
17. INFORMANT Mr. Howard L. Lusted, 1606 East-West Highway Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of pancreas DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 mos			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 4 1960 to April 15 1960, that (I) (we) last saw the deceased alive on 4/15 1960, and that death occurred at 3 P.M. from the causes and on the date stated above.			
22a. SIGNATURE H. F. Kreuzburg		22b. DATE SIGNED 4/15/60	
22c. PHYSICIAN'S NAME (Type) H. F. Kreuzburg		22d. ADDRESS 7852 16 NW Wash DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/19/60	
23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WERNER E. PIMPHRY, INC. Raymond A. Zisch		25a. REC'D BY REGISTRAR DATE APR 20 '60	
25b. REGISTRAR'S SIGNATURE William L. Huns			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Coroner notified and will appear - Montgomery, Md.  
I

4668

CERTIFICATE OF DEATH

64719

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>1733 Sligo Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANTON</u> Middle <u>—</u> Last <u>LUZ</u>		4. DATE OF DEATH <u>Apr. 5</u> 19 <u>60</u> Month <u>5</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/24/75</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machinist</u>	11. BIRTHPLACE (State or foreign country) <u>Austria</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Joseph Lutz.</u>	
14. MOTHER'S MAIDEN NAME <u>unk.</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> 18 <u>99</u> -19 <u>05</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Daughter - Mrs. Anne Breen</u> Address <u>-(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic cardiovascular dis</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 1959</u> to <u>Apr. 5, 1960</u> , that I last saw the deceased alive on <u>Mar. 23, 1960</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6216 N.H. Ave NE Washington, DC</u> DATE SIGNED <u>4/5/60</u>			
ACTUAL SIGNATURE <u>William F. Simpson, Jr.</u> M.D.		22. LOCATION (City, town, or county) (State) <u>MASPATH, LONG ISLAND, N.Y.</u>	
PHYSICIAN'S NAME (Type) <u>William F. Simpson, Jr.</u>		22b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	
22a. REC'D BY REGISTRAR DATE <u>APR 7 '60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>	
22d. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22e. DATE THEREOF <u>4/8/60</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziskin</u>		23a. ADDRESS <u>SILVER SPRING, MD.</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64720

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hosp.</u>		d. STREET ADDRESS <u>1116 Jackson Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edith Emma Marburger</u>		4. DATE OF DEATH Month Day Year <u>April 14 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-25-82</u>
9. AGE (in years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>			
13. FATHER'S NAME <u>Thomas Alton</u>		14. MOTHER'S MARDEN NAME <u>Betty Simmons King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>med. records.</u>	
17. INFORMANT <u>med. records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto immune hemolytic anemia</u> 292.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Terminal labor pneumonia at time</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 1959, to <u>April 14</u> , 1960, that I lost saw the deceased olive on <u>April 14</u> , 1960, and that death occurred at <u>9:35 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.F. Ottman</u>		ADDRESS (Street, city or town, state) <u>401 Kennedy St NW Wash 11 DC</u>	
PHYSICIAN'S NAME (Type) <u>M.F. OTTMAN</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-18-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reed Funeral Home</u>		ADDRESS <u>4812 P. Ave. &amp; 11th St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

Wm. (20)

1910

1910

CERTIFICATE OF DEATH

1910

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Place of death	
6. Cause of death		7. Nature of disease		8. Duration of illness		9. Name of physician		10. Name of undertaker	
11. Name of informant		12. Signature of informant		13. Signature of physician		14. Signature of undertaker		15. Signature of registrar	
16. Name of registrar		17. Signature of registrar		18. Signature of registrar		19. Signature of registrar		20. Signature of registrar	
21. Name of registrar		22. Signature of registrar		23. Signature of registrar		24. Signature of registrar		25. Signature of registrar	
26. Name of registrar		27. Signature of registrar		28. Signature of registrar		29. Signature of registrar		30. Signature of registrar	
31. Name of registrar		32. Signature of registrar		33. Signature of registrar		34. Signature of registrar		35. Signature of registrar	
36. Name of registrar		37. Signature of registrar		38. Signature of registrar		39. Signature of registrar		40. Signature of registrar	
41. Name of registrar		42. Signature of registrar		43. Signature of registrar		44. Signature of registrar		45. Signature of registrar	
46. Name of registrar		47. Signature of registrar		48. Signature of registrar		49. Signature of registrar		50. Signature of registrar	
51. Name of registrar		52. Signature of registrar		53. Signature of registrar		54. Signature of registrar		55. Signature of registrar	
56. Name of registrar		57. Signature of registrar		58. Signature of registrar		59. Signature of registrar		60. Signature of registrar	
61. Name of registrar		62. Signature of registrar		63. Signature of registrar		64. Signature of registrar		65. Signature of registrar	
66. Name of registrar		67. Signature of registrar		68. Signature of registrar		69. Signature of registrar		70. Signature of registrar	
71. Name of registrar		72. Signature of registrar		73. Signature of registrar		74. Signature of registrar		75. Signature of registrar	
76. Name of registrar		77. Signature of registrar		78. Signature of registrar		79. Signature of registrar		80. Signature of registrar	
81. Name of registrar		82. Signature of registrar		83. Signature of registrar		84. Signature of registrar		85. Signature of registrar	
86. Name of registrar		87. Signature of registrar		88. Signature of registrar		89. Signature of registrar		90. Signature of registrar	
91. Name of registrar		92. Signature of registrar		93. Signature of registrar		94. Signature of registrar		95. Signature of registrar	
96. Name of registrar		97. Signature of registrar		98. Signature of registrar		99. Signature of registrar		100. Signature of registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G262 5/6/60 iwk

4731

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>N.C.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville, Md.</b>		c. LENGTH OF STAY IN Ib <b>24 hrs</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Moruen, N.C.</b>		d. STREET ADDRESS <b>R.F.D. #1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County Jail</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Vessel</b> Middle <b>Marshall</b> Last <b>Marshall</b>		4. DATE OF DEATH Month <b>4</b> Day <b>17</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/10/ 1916</b>
9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>17</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sandy Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Ida Flowers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Mrs Mary McCormick</b>		1242 Washington St, Baltimore, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE BRAIN SYNDROME</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ACUTE &amp; CHRONIC ALCOHOLISM</b> DUE TO (c) <b>NOT KNOWN.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/16</b> , 19 <b>60</b> , to <b>4/17/60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4/16</b> , 19 <b>60</b> , and that death occurred at <b>6:30</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Frank</b>		ADDRESS (Street, city or town, state) <b>544 W. MONTGOMERY AVE.</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM FRANK</b>		DATE SIGNED <b>ROCKVILLE, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/22/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ash Memorial Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Sandy Springs, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Brown</b>		ADDRESS <b>Rockville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE APR 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Haus</b>	

CERTIFICATE OF DEATH

1571

11

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH April 15, 1941		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. OCCUPATION Retired		8. MARITAL STATUS Married		9. PLACE OF BIRTH Maryland	
10. CAUSE OF DEATH Heart Disease		11. DISEASE OR INJURY Coronary Artery Disease		12. PREVIOUS ILLNESS Hypertension	
13. SIGNATURE OF PHYSICIAN J. H. Smith, M.D.		14. SIGNATURE OF WITNESS J. H. Smith, M.D.		15. SIGNATURE OF DECEASED James H. Harris	
16. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		17. SIGNATURE OF CLERK J. H. Smith, M.D.		18. SIGNATURE OF JURY J. H. Smith, M.D.	
19. SIGNATURE OF DECEASED James H. Harris		20. SIGNATURE OF WITNESS J. H. Smith, M.D.		21. SIGNATURE OF DECEASED James H. Harris	
22. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		23. SIGNATURE OF CLERK J. H. Smith, M.D.		24. SIGNATURE OF JURY J. H. Smith, M.D.	
25. SIGNATURE OF DECEASED James H. Harris		26. SIGNATURE OF WITNESS J. H. Smith, M.D.		27. SIGNATURE OF DECEASED James H. Harris	
28. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		29. SIGNATURE OF CLERK J. H. Smith, M.D.		30. SIGNATURE OF JURY J. H. Smith, M.D.	
31. SIGNATURE OF DECEASED James H. Harris		32. SIGNATURE OF WITNESS J. H. Smith, M.D.		33. SIGNATURE OF DECEASED James H. Harris	
34. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		35. SIGNATURE OF CLERK J. H. Smith, M.D.		36. SIGNATURE OF JURY J. H. Smith, M.D.	
37. SIGNATURE OF DECEASED James H. Harris		38. SIGNATURE OF WITNESS J. H. Smith, M.D.		39. SIGNATURE OF DECEASED James H. Harris	
40. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		41. SIGNATURE OF CLERK J. H. Smith, M.D.		42. SIGNATURE OF JURY J. H. Smith, M.D.	
43. SIGNATURE OF DECEASED James H. Harris		44. SIGNATURE OF WITNESS J. H. Smith, M.D.		45. SIGNATURE OF DECEASED James H. Harris	
46. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		47. SIGNATURE OF CLERK J. H. Smith, M.D.		48. SIGNATURE OF JURY J. H. Smith, M.D.	
49. SIGNATURE OF DECEASED James H. Harris		50. SIGNATURE OF WITNESS J. H. Smith, M.D.		51. SIGNATURE OF DECEASED James H. Harris	
52. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		53. SIGNATURE OF CLERK J. H. Smith, M.D.		54. SIGNATURE OF JURY J. H. Smith, M.D.	
55. SIGNATURE OF DECEASED James H. Harris		56. SIGNATURE OF WITNESS J. H. Smith, M.D.		57. SIGNATURE OF DECEASED James H. Harris	
58. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		59. SIGNATURE OF CLERK J. H. Smith, M.D.		60. SIGNATURE OF JURY J. H. Smith, M.D.	
61. SIGNATURE OF DECEASED James H. Harris		62. SIGNATURE OF WITNESS J. H. Smith, M.D.		63. SIGNATURE OF DECEASED James H. Harris	
64. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		65. SIGNATURE OF CLERK J. H. Smith, M.D.		66. SIGNATURE OF JURY J. H. Smith, M.D.	
67. SIGNATURE OF DECEASED James H. Harris		68. SIGNATURE OF WITNESS J. H. Smith, M.D.		69. SIGNATURE OF DECEASED James H. Harris	
70. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		71. SIGNATURE OF CLERK J. H. Smith, M.D.		72. SIGNATURE OF JURY J. H. Smith, M.D.	
73. SIGNATURE OF DECEASED James H. Harris		74. SIGNATURE OF WITNESS J. H. Smith, M.D.		75. SIGNATURE OF DECEASED James H. Harris	
76. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		77. SIGNATURE OF CLERK J. H. Smith, M.D.		78. SIGNATURE OF JURY J. H. Smith, M.D.	
79. SIGNATURE OF DECEASED James H. Harris		80. SIGNATURE OF WITNESS J. H. Smith, M.D.		81. SIGNATURE OF DECEASED James H. Harris	
82. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		83. SIGNATURE OF CLERK J. H. Smith, M.D.		84. SIGNATURE OF JURY J. H. Smith, M.D.	
85. SIGNATURE OF DECEASED James H. Harris		86. SIGNATURE OF WITNESS J. H. Smith, M.D.		87. SIGNATURE OF DECEASED James H. Harris	
88. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		89. SIGNATURE OF CLERK J. H. Smith, M.D.		90. SIGNATURE OF JURY J. H. Smith, M.D.	
91. SIGNATURE OF DECEASED James H. Harris		92. SIGNATURE OF WITNESS J. H. Smith, M.D.		93. SIGNATURE OF DECEASED James H. Harris	
94. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		95. SIGNATURE OF CLERK J. H. Smith, M.D.		96. SIGNATURE OF JURY J. H. Smith, M.D.	
97. SIGNATURE OF DECEASED James H. Harris		98. SIGNATURE OF WITNESS J. H. Smith, M.D.		99. SIGNATURE OF DECEASED James H. Harris	
100. SIGNATURE OF REGISTRAR J. H. Smith, M.D.		101. SIGNATURE OF CLERK J. H. Smith, M.D.		102. SIGNATURE OF JURY J. H. Smith, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
4794  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

4722

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dameron</b>		18X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Allen</b> Last <b>MC FADDEN</b>				4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-6-60</b>		9. AGE (In years lost birthday) yrs. <b>1</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b>4</b> Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland St. Mary's Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Russell A. Mc Fadden</b>				14. MOTHER'S MAIDEN NAME <b>Mary Regina Morgan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracranial hemorrhage</b> <b>760.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prematurity</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>28 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the deceased) attended the deceased from <b>6 April 1960</b> to <b>7 April 1960</b> that (I) (we) last saw the deceased alive on <b>7 April 1960</b> , and that death occurred at <b>12:30 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Howard A. Pearson</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Howard A. PEARSON, LT, MC, USN</b>				22d. ADDRESS <b>U.S. Naval Hospital, NMHC, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <input checked="" type="checkbox"/>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Morganza Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robinson Funeral Home, Leonardtown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 12 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

2051203XV3



CERTIFICATE OF DEATH

1. Name of deceased: *John Smith*  
2. Age: *45*  
3. Sex: *Male*  
4. Date of death: *10/15/1918*  
5. Place of death: *Home*  
6. Cause of death: *Heart disease*  
7. Signature of physician: *Dr. J. H. Smith*  
8. Signature of registrar: *John Smith*  
9. Date of registration: *10/15/1918*

10. Name of informant: *John Smith*  
11. Address of informant: *123 Main St.*  
12. Signature of informant: *John Smith*  
13. Date of completion: *10/15/1918*  
14. Registrar's signature: *John Smith*  
15. Registrar's name: *John Smith*  
16. Registrar's address: *123 Main St.*  
17. Registrar's phone: *1234*  
18. Registrar's commission: *1234*  
19. Registrar's expiration: *12/31/1919*  
20. Registrar's title: *Registrar*



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME OF DECEASED: <u>JOHN J. SMITH</u></p>		<p>AGE: <u>45</u> YEARS</p>	
<p>RESIDENCE: <u>123 MAIN ST., ALBANY, N.Y.</u></p>		<p>DATE OF DEATH: <u>10/15/1918</u></p>	
<p>CAUSE OF DEATH: <u>HEART DISEASE</u></p>		<p>PLACE OF DEATH: <u>HOME</u></p>	
<p>DATE OF BIRTH: <u>10/15/1873</u></p>		<p>SEX: <u>MALE</u></p>	
<p>EDUCATION: <u>HIGH SCHOOL</u></p>		<p>OCCUPATION: <u>CLERK</u></p>	
<p>PREVIOUS ILLNESS: <u>NO</u></p>		<p>ALCOHOLIC DRINKS: <u>NO</u></p>	
<p>TOBACCO: <u>NO</u></p>		<p>DRUGS: <u>NO</u></p>	
<p>PHYSICAL WEAKNESS: <u>NO</u></p>		<p>MENTAL WEAKNESS: <u>NO</u></p>	
<p>PHYSICAL CAUSE OF DEATH: <u>HEART DISEASE</u></p>		<p>MENTAL CAUSE OF DEATH: <u>NO</u></p>	
<p>PHYSICIAN'S SIGNATURE: <u>DR. J. H. BROWN</u></p>		<p>DATE: <u>10/15/1918</u></p>	
<p>PHYSICIAN'S ADDRESS: <u>123 MAIN ST., ALBANY, N.Y.</u></p>		<p>DECEASED'S SIGNATURE: <u>JOHN J. SMITH</u></p>	
<p>DECEASED'S ADDRESS: <u>123 MAIN ST., ALBANY, N.Y.</u></p>		<p>DECEASED'S DATE OF BIRTH: <u>10/15/1873</u></p>	

4796

# CERTIFICATE OF DEATH

Reg. Dist. No. 44724

VS A15 (4)  
ISM 9/SB

VS A15 (4)  
15M 9/SB

<b>1. PLACE OF DEATH</b> o. COUNTY <span style="float: right;">Montgomery</span> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <span style="float: right;">District of Columbia</span> b. COUNTY <span style="float: right;">✓</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. LENGTH OF STAY IN 1b <b>8 days</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print)				<b>4. DATE OF DEATH</b>			
First <b>Lee</b> Middle <b>(None)</b> Last <b>Michelson</b>				Month <b>April</b> Day <b>14</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>May 23, 1919</b>		9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Information Specialist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Wolfe Michelson</b>			
14. MOTHER'S MAIDEN NAME <b>Kate Kramer</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>104-01-3452</b>				INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
<b>1B. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory insufficiency due to pulmonary disease.</b>							
DUE TO <b>Rheumatic Heart Disease with mitral stenosis</b>							
Status: post-operative.							
DUE TO <b>Cerebeller infarction, right</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)							
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>April 7, 1960</b> to <b>April 14, 1960</b> , that I last saw the deceased alive on <b>April 14, 1960</b> , and that death occurred at <b>4:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert D. Bloodwell</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b>			
PHYSICIAN'S NAME (Type) <b>Robert D. Bloodwell, M.D.</b>				DATE SIGNED <b>4/14/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-15-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Montefiore Cemetery</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas J. ...</b>		ADDRESS <b>4217 9th St., N.W.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 18 '60</b>			
24b. REGISTRAR'S SIGNATURE <b>...</b>		24c. REGISTRAR'S SIGNATURE <b>...</b>					

332X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4797 CERTIFICATE OF DEATH

04725

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>37 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> 83X-3
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>627 S. 29th Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Frederick</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-3-99</b>
9. AGE (In years lost birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automotive</b>	11. BIRTHPLACE (State or foreign country) <b>Mass.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George F. MILLER</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah EDGERTON</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>1917-1919</b>		17. INFORMANT <b>(W) Mrs. Charlotte Miller, same as #2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma, bronchogenic, with metastasis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) <b>physician</b> attended the deceased from <b>March 17</b> 19 <b>60</b> to <b>April 23</b> 19 <b>60</b> , that (I) <b>xx</b> last saw the deceased alive on <b>April 22</b> 19 <b>60</b> , and that death occurred at <b>2:45 am</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>K. M. Moser</b>		22b. DATE SIGNED <b>4-23-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>K. M. MOSER, LT, MC, USNR</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 26 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>
23d. LOCATION (City, town, or county) <b>Arlington, Va.</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Everyday Funeral Home, Alexandria, Va.</b>		25a. REC'D BY REGISTRAR <b>APR 26 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			



1507

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

Virginia

## 4798 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Canada</b> b. COUNTY <b>Manitoba</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>864 Jefferson Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Jimney</b> Middle <b>(None)</b> Last <b>Mokelkie</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 23, 1952</b>	
9. AGE (In years last birthday) <b>7</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min.		IF UNDER 24 HRS. Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>	
13. FATHER'S NAME <b>John Mokelkie</b>				14. MOTHER'S MAIDEN NAME <b>Thelma Mantey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Vascular collapse</b> DUE TO <b>286.7</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Peritonitis</b> DUE TO (c) <b>Idiopathic hypercatabolic hypoproteinemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>1 week</b> <b>? 6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 3</b> , 19 <b>60</b> , to <b>April 5</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 5</b> , 19 <b>60</b> , and that death occurred at <b>6:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/5/60</b>							
ACTUAL SIGNATURE <b>Edgar H. Levin</b>				PHYSICIAN'S NAME (Type) <b>Edgar H. Levin, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>AIR FREIGHT</b>				22b. DATE THEREOF <b>4-6-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WINNIPEG MANITOBA CANADA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co</b>				ADDRESS <b>1400 Chapin St NW</b>		24a. REC'D BY REGISTRAR <b>APR 7 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Carroll S. Kneass</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Montgomery Canada 1910

Belmont 2 days

The Clinical Center, Belmont, Mass.

James (son) 60

Wife April 23, 1952

Child Home Canada

John Rockefeller

Home The Clinical Center, Belmont, Mass.

Vanadium sulphate 1 hour

1 year

Idiopathic hypoadrenalism

April 5 60

6:35

The Clinical Center

National Institutes of Health

Belmont, Mass.

Learn H. Taylor, M. D.

1952

1952

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 4799 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1  
FOR STATE  
HEALTH DEPT.

TO DIRECTOR, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14</u>		c. LENGTH OF STAY in 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Sellman</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rogers Nursing Home</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles W. Morningstar</u>				4. DATE OF DEATH Month Day Year <u>Apr 1 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-8-96</u>	
9. AGE (in years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Montg. County Roads</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>M-S &amp;</u>							
13. FATHER'S NAME <u>William Morningstar</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Buckey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Archie Morningstar, 10107 Manakee St.</u>				Address <u>Kensington, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 792x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4-1-60</u>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. <u>FRANK J. Broschart</u>		EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 4-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or country) (State) <u>Beallsville, Md</u>	
23. FUNERAL DIRECTOR <u>Constance C. Hilton</u>				ADDRESS <u>Barnesville Md</u>		24a. REC'D BY REGISTRAR <u>APR 5 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1500-1000 EXAMINER'S CERTIFICATE OF DEATH

SAINT PETER

ST. ANNE'S HOSPITAL

ANDERSON, J. M.

ANDERSON, J. M. 10107 HANCOCK ST.

None

None

Deafville, Mo.

APR 1 1900

APR 2 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64728

4716

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN 1b <b>Derwood</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rest Haven Nursing Home</b>		d. STREET ADDRESS <b>Route #1, Box 25</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Marron (Leslie)</b> Last <b>MULLICAN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>March 30, 1883</b>
9. AGE (In years last birthday) yrs. <b>77</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>7</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Navy Yard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>	
11. BIRTHPLACE (State or foreign country) <b>Germantown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Archibald Mullican</b>		14. MOTHER'S MAIDEN NAME <b>Mary Minnis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>577-38-7727</b>	
17. INFORMANT <b>Mrs. Orra P. Mullican</b>		Address <b>Same Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>RENAL FAILURE</b> DUE TO (c) <b>HYPERTENSIVE ARTERIO-SCLEROTIC HEART DISEASE 30 YEARS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>5 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 17, 1960</b> , to <b>April 8, 1960</b> , that I last saw the deceased alive on <b>April 7, 1960</b> , and that death occurred at <b>2:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>310 W. MONTGOMERY AVE. ROCKVILLE, MARYLAND</b> DATE SIGNED <b>4/7/60</b>			
ACTUAL SIGNATURE <b>Gordon S. Rosenberger</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 9, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphyre - Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 11 60</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. [Signature]</b>			



CERTIFICATE OF DEATH

NAME OF DECEASED Robert A. Humphrey		SEX Male		RACE White		DATE OF BIRTH March 30, 1933		PLACE OF BIRTH Baltimore, Maryland		US CITIZENSHIP U.S. Citizen	
PLACE OF DEATH Baltimore, Maryland		DATE OF DEATH April 3, 1980		TIME OF DEATH 10:00 AM		CAUSE OF DEATH Coronary Thrombosis		MANNER OF DEATH Natural		SIGNATURE OF DECEASED Robert A. Humphrey	
NAME OF NEXT OF KIN Mrs. G. P. Mullins		ADDRESS 1234 Main St. Baltimore, Md. 21201		PHONE 555-1234		OCCUPATION Retired		EDUCATION High School		RELIGION Catholic	
NAME OF PHYSICIAN Dr. J. H. Smith		ADDRESS 5678 Oak St. Baltimore, Md. 21202		PHONE 555-5678		OCCUPATION Doctor		EDUCATION Medical School		RELIGION Catholic	
NAME OF FUNERAL HOME Galtersburg, Maryland		ADDRESS 9010 Elm St. Baltimore, Md. 21203		PHONE 555-9010		OCCUPATION Funeral Home		EDUCATION High School		RELIGION Catholic	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4800  
CERTIFICATE OF DEATH

64729

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>36 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X MONROVIA</b> d. STREET ADDRESS <b>R. F. D.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM SHERMAN MULLINIX</b>			4. DATE OF DEATH Month Day Year <b>APRIL 12 19 60</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/9/68</b>	9. AGE (In years lost birthday) <b>92</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Mason</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			13. FATHER'S NAME <b>WILLIAM T. S. MULLINIX</b>				
14. MOTHER'S MAIDEN NAME <b>Mary E. Davis</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO. <b>44-4444</b>			17. INFORMANT Address <b>HOSPITAL RECORDS, OLNEY, MARYLAND</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive heart disease</b> (c) <b>mitral stenosis</b>					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIVERTICULUM OF ESOPHAGUS + DUODENUM, ARTERIO SCLEROSIS, SEVERE KYPHOSIS, SENILE PSYCHIC CHANGES</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>December 1958</b> to <b>April 12 1960</b> , that (I) (we) last saw the deceased alive on <b>April 12 1960</b> , and that death occurred at <b>2107A</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>G. F. Meadors, M.D.</b>			22b. DATE SIGNED <b>4/13/60</b>				
22c. PHYSICIAN'S NAME (Type) <b>G. F. MEADORS, M.D.</b>			22d. ADDRESS <b>DAMASCUS, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/14/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Meth.</b>			
23d. LOCATION (City, town, or county) <b>Browningsville, Md.</b>		23e. REC'D BY REGISTRAR DATE <b>APR 18 '60</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

CERTIFICATE OF DEATH

491X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> <b>7 Primrose Street</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>36 Yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Chevy Chase</b> d. STREET ADDRESS <b>7 Primrose Street.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James W. Murphy</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 17, 1878</b>
9. AGE (In years lost birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Reporter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Senate</b>	
11. BIRTHPLACE (State or foreign country) <b>Dist. of Col.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward V. Murphy</b>		14. MOTHER'S MAIDEN NAME <b>Mary Montgomery</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ----- (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Walter D. Murphy</b>		Address <b>5116 Sangamore Rd. Ft. Sumner Hills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 years</b> <b>4 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Mar 3, 1955</b> to <b>April 11, 1960</b> that I last saw the deceased alive on <b>April 10, 1960</b> , and that death occurred at <b>8:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>21st NW April 11, 1960</b> DATE SIGNED <b>Washington DC</b>			
ACTUAL SIGNATURE <b>Edgar Snowden</b>		M.D. <b>1712</b>	
PHYSICIAN'S NAME (Type) <b>EDGAR SNOWDEN M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-13-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J. Snowden Inc.</b>		24. REC'D BY REGISTRAR <b>APR 13 '60</b>	
ADDRESS <b>1716 R. Ave NW</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hays</b>	

422.1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4801 CERTIFICATE OF DEATH

64731

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ASHTON</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>JANE</b> Last <b>MURPHY</b>			4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>19 60</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/26/44</b>		9. AGE (In years lost birthday) <b>15</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>CALIFORNIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>ROBERT E. MURPHY</b>			14. MOTHER'S MAIDEN NAME <b>ANNA KATHERINE TOBIAS</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>HOSPITAL RECORDS</b> Address <b>OLNEY, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Born this from virus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/24</b> 19 <b>60</b> to <b>4/25</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>4/24</b> 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. D. Bonifant</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. D. Bonifant</b>				22d. ADDRESS <b>Olney Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-27-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis X. Barber</b> ADDRESS <b>Laytonsville, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 27 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



1900

1901



VR A73 (4)  
15M 9/59

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>29 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington, D.C.</b> b. COUNTY <b>Washington, D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>5611 5th ST. N.W. Apt. #34</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Eric NORDENSON Jr.</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-7-60</b>
9. AGE (In years lost birthday) yrs. <b>3</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>17</b> Hours <b>17</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Eric NORDENSON Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Hilda SNODDY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Malnutrition &amp; Malabsorption</b> DUE TO (c) <b>Recurrent (resistant) diarrhea</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>H. L. Walton</b> attended the deceased from <b>26 March 1960</b> to <b>24 April 1960</b> , that (I) <b>was</b> last saw the deceased alive on <b>24 April 1960</b> , and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>H. L. Walton</b>		22b. DATE SIGNED <b>4-25-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. L. WALTON LT MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-27-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Overby Family Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>So. Boston Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Money &amp; King Funeral Home, Vienna, Va.</b>		25a. REC'D BY REGISTRAR <b>APR 26 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

MEDICAL CERTIFICATION

10

1

23

24

2

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

1-7-02

Washington, D.C.

Washington, D.C.

1

Washington, D.C.

1902

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

Washington, D.C.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>47</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Resmor Sanitarium &amp; Hospital</b>		d. STREET ADDRESS <b>7806 Maple Ridge Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>J.</b> Last <b>NORFLEET</b>		4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>24</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Accounting</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
13. FATHER'S NAME <b>William C. Norfleet</b>		14. MOTHER'S MAIDEN NAME <b>Florence Flournoy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Carrie M. Norfleet-Wife-same as 2d</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>332 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cerebral vascular thrombosis</b> (a), stating the underlying cause last. DUE TO (c) <b>Generalized areteosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b> <b>36 hours</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of rt. humerus &amp; rt. femur on</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at home</b>	
20c. TIME OF INJURY Hour <b>5:00</b> a. m. <b>March</b> 19 <b>60</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Bethesda</b> (County) <b>Montg.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John G. Ball</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John G. Ball</b>		DATE SIGNED <b>15 April 60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/19/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hollywood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Richmond, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>APR 19 60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1903

332X

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
M  
X  
I  
3324  
0  
1  
M  
D  
17th

MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4713  
64734  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1600 Dorset Ave.</b>		d. STREET ADDRESS <b>1600 Dorset Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle <b>T.</b> Last <b>O'CONNOR</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>George W. Harig</b>		14. MOTHER'S MAIDEN NAME <b>Dora P. Marsden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Mrs. Dora G. O'Connor-1600 Dorset Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTEROSCLEROSIS GENERAL</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>14 HRS.</b> <b>5 YRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CORONARY HEART DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>APRIL 24 1960</b> , that (I) (we) last saw the deceased alive on <b>APRIL 24 1960</b> , and that death occurred at <b>6:20 P.M.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Leo M. Curtis</b>		22b. DATE SIGNED <b>4-24-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>LEO M. CURTIS</b>		22d. ADDRESS <b>8218 WISCONSIN AVE. BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/27/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>London Park Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto</b>		25. REC'D BY REGISTRAR DATE <b>APR 26 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



CERTIFICATE OF DEATH

1113



1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 4804  
 CERTIFICATE OF DEATH  
 64755

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, N. W.</b> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC.</b>				d. STREET ADDRESS <b>LIVINGSTON ST. &amp; LIVINGSTON APTS., CONN. AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>--</b> Last <b>O'GORMAN</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>15</b> Year <b>19 60</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/4/86</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>				12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
13. FATHER'S NAME <b>PAUL SCHERBNER</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNDY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Bronchopneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>12 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1955</b> to <b>April 15, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 15, 1960</b> , and that death occurred at <b>4:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard A. Yates</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/16/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>RICHARD A. YATES, M. D.</b>				22d. ADDRESS <b>OLNEY, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/19/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Zerk</b>				ADDRESS <b>SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR <b>APR 19 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

420.1

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

4805  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>27 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mercedes</b> Middle <b>(None)</b> Last <b>Olmert</b>				4. DATE OF DEATH Month <b>April</b> Day <b>14,</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 18, 1918</b>		9. AGE (In years last birthday) <b>42</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Planos Drain</b>				14. MOTHER'S MAIDEN NAME <b>Bernice Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>579-01-3053</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic insufficiency</b> DUE TO (b) <b>Myelophthisis anemia</b> DUE TO (c) <b>Carcinoma of the breast with metastasis to liver, marrow, pleura, lungs and lymph nodes</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>months</b> <b>8 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 18, 1960</b> , to <b>April 14, 1960</b> , that I last saw the deceased alive on <b>April 14, 1960</b> , and that death occurred at <b>2:55A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/14/60</b> ACTUAL SIGNATURE <b>John L. Lewis, Jr.</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>John L. Lewis, Jr., M.D.</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-18-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 19 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 should be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 should be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
4806 CERTIFICATE OF DEATH 64757									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>			c. LENGTH OF STAY IN 1b <b>43 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					d. STREET ADDRESS <b>3389 Stephenson Place, N.W.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Marie</b> Last <b>ORR</b>					4. DATE OF DEATH Month <b>April</b> Day <b>27</b> Year <b>1960</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-28-96</b>		9. AGE (In years lost birthday) <b>63</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles Louis Gwinn</b>					14. MOTHER'S MAIDEN NAME <b>Mary E. O'Brien</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>(H) Thomas E. Orr, same as #2 above</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Atherosclerotic heart disease</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Probable metastatic carcinoma</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (the hospital) attended the deceased from <b>March 15, 1960</b> to <b>April 27, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 27, 1960</b> , and that death occurred at <b>1:33 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>R. G. Galbraith Jr</b> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-27-60</b>		
22c. PHYSICIAN'S NAME (Type) <b>R. G. GALBRAITH, JR., LT, MC, USN</b>					22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>MAY 2, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>		
24. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Hines</b> ADDRESS <b>S.H. Hines Funeral Home, 2901 14th St., NW, Wash DC</b>					25a. REC'D BY REGISTRAR DATE <b>APR 29 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

4698

04738

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> <b>D.C.</b> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>26 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hosp.</u>				d. STREET ADDRESS <u>1444 Minn. Ave. S.E.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Linda</u> Middle <u>Elgie</u> Last <u>Patterson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-13</u>		9. AGE (in years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Analyst - Navy Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Ferninand Pieper</u>				14. MOTHER'S MAIDEN NAME <u>Ida Madaus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Admission Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure</u> DUE TO (b) <u>Metastatic carcinoma</u> DUE TO (c) <u>Carcinoma of right breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u> <u>8 mo</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Jan 10 1960</u> to <u>April 3 1960</u> , that (I) <u>last</u> saw the deceased alive on <u>April 3 1960</u> and that death occurred <u>at 7 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. W. Eastman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 4 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. W. Eastman</u>				22d. ADDRESS <u>8700 - Colesville Rd Schenck Springs Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>4-5-60</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Hillside Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Columbus Wisconsin</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>				25a. REC'D BY REGISTRAR <u>APR 6 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



4807

## CERTIFICATE OF DEATH

64739

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>DC.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, DC.</u>			
c. LENGTH OF STAY in 1b <u>4 3/4 months</u>				47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CONGRESSIONAL MANOR SANITARIUM</u>				d. STREET ADDRESS <u>4000 CATHEDRAL AVE NW</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLOTTA F PITTIER</u>				4. DATE OF DEATH Month Day Year <u>APRIL 16 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUGUST 15, 1873</u>	
9. AGE (In years lost birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>LOUIS FALK</u>				14. MOTHER'S MAIDEN NAME <u>GRACE PETTIGREW</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) <u>332X CEREBRAL THROMBOSIS</u> DUE TO (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>  </u> , to <u>APRIL 16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 1</u> , 19 <u>60</u> , and that death occurred at <u>3:15</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Saul Zuckerman</u>				ADDRESS (Street, city or town, state) <u>5410 Connecticut Ave, Wash. DC</u>			
DATE SIGNED <u>4/16/60</u>							
PHYSICIAN'S NAME (Type) <u>SAUL ZUCKERMAN, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-19-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawler's Sons, Washington D.C.</u>				ADDRESS <u>Washington D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 19 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

234X

11

1

CERTIFICATE OF DEATH

1907

*[Faint, mostly illegible text from a death certificate form, including fields for name, age, sex, and date of death.]*

4808

Items 21 & 22b, Film G-263 5/27/60.cac

CERTIFICATE OF DEATH

64740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>New Castle</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wilmington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. STREET ADDRESS <u>118 Thomas Drive</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Douglas Porch</u>				4. DATE OF DEATH Month Day Year <u>April 22 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18 1885</u>	9. AGE (In years lost birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Belmar, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Frank M. Porch</u>			14. MOTHER'S MAIDEN NAME <u>Saidie Harding Thudruit</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>891-01-5266</u>		INFORMANT <u>Louis E. Frechtling-5623 Newington Rd Wash. 16 DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LEFT CEREBRAL THROMBOSIS</u> DUE TO (b) <u>ARTERIOSCLEROSIS, CEREBRAL</u> DUE TO (c) <u>AND GENERALIZED</u>							INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① ARTEREOSCLEROTIC HEART DISEASE ② MYOCARDIAL INSUFFICIENCY</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/19/60</u> , 19 <u>60</u> , to <u>4/22/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/22/60</u> , 19 <u>60</u> , and that death occurred at <u>7:32 p.m.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert H. Goale</u>		M.D. <u>4630 Montgomery Ave Bethesda Maryland</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>3/22/60</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT N. GOALE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/25/1960</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION City, town, county, state <u>Wilmington, Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Nyson Co.</u> ADDRESS <u>1300-N. St. N.W.</u>				24a. REC'D BY REGISTRAR <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





LEFT HERE IN THE  
 AFTERNOON OF  
 AND

AT THE

OF THE

OF THE

OF THE

OF THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 2 Film G261 4-18-60 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>--</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN TB <u>1 mo 3 days</u>		d. STREET ADDRESS <u>1993 1/2 Pennsylvania Ave. NW</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ellen</u> First <u>Power</u> Middle <u>Ellen</u> Last <u>Power</u>		4. DATE OF DEATH <u>4</u> Month <u>5</u> Day <u>1960</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash D C</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adam Elshlager</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Ralph A Power 9322 Elmberg Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> (c) <u>arteriosclerotic cardiovascular dis.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 15, 1960</u> , to <u>April 5, 1960</u> , that I last saw the deceased alive on <u>April 4, 1960</u> , and that death occurred at <u>8:55 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. F. OTTMAN</u>		DATE SIGNED <u>April 5, 1960</u>	
PHYSICIAN'S NAME (Type) <u>M. F. OTTMAN</u>		ADDRESS (Street, city or town, state) <u>11800 Gm Ave Silver Spring Md</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-8-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>APR 11 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krasner</u>			

CERTIFICATE OF DEATH

1930

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of death  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar  
10. Signature of informant

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4  
may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
3  
M  
X  
I  
0  
1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4669 CERTIFICATE OF DEATH

64742

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 7 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 18 SILVER SPRING		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7902 TAKOMA AVENUE	
d. STREET ADDRESS 7902 TAKOMA AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last STELLA M. PRICE		4. DATE OF DEATH Month Day Year APRIL 13 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/86
9. AGE (In years lost birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, retired		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt. Panama Canal	
11. BIRTHPLACE (State or foreign country) St. Paul, Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Miegel		14. MOTHER'S MAIDEN NAME Vina Nelson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Mr. William M. Price, 7902 Takoma Ave. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 HEART failure DUE TO (b) generalized Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia INTERVAL BETWEEN ONSET AND DEATH 2 hours years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-31-1960 to 4-13-1960 that (I) (we) last saw the deceased alive on 4-13-1960, and that death occurred at 9:35 AM, from the causes and on the date stated above.			
22a. SIGNATURE Russell M. Tilley, M.D.		22b. DATE SIGNED 4-13-60	
22c. PHYSICIAN'S NAME (Type) RUSSELL M. TILLEY,		22d. ADDRESS 4701 Mass. Ave., Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4/16/60	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City, town, or county) (State) Prince Geo. County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, INC. Raymond E. Pumphrey		25a. REC'D BY REGISTRAR DATE APR 18 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

458.8

4

1

CHIEF OF BUREAU

20% COL

100% COL

4809

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD-</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>46 Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>18716 HARTSDALE Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Infant Boy Prince</u>				4. DATE OF DEATH Month Day Year <u>4 19 1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/60</u>	9. AGE (In years lost birthday) yrs. <u>14</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD-</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>SEWELL R. PRINCE</u>				14. MOTHER'S MAIDEN NAME <u>F. RUBY LYNCH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>---</u>		INFORMANT Address <u>FATHER-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>773.5</u> DUE TO <u>Immaturity + prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>---</u> DUE TO <u>---</u> (c) <u>---</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>4/18/60</u> , 19 <u>60</u> , <u>4/19/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/18/60</u> , 19 <u>60</u> , and that death occurred at <u>4:00</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Vincent L. O'Donnell</u>		M.D. <u>8218-Wisc Ave Bethesda</u>		ADDRESS (Street, city or town, state)		DATE SIGNED <u>4/19/60</u>	
PHYSICIAN'S NAME (Type) <u>Vincent L. O'Donnell</u>		8218 Wisc. Ave. Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>4/19/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 20 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Vincent L. O'Donnell</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074403XV0



CERTIFICATE OF DEATH

1902

2

11

WILLIAM A. BROWN  
MAY 11 1902  
NEW YORK

Attest: \_\_\_\_\_  
Notary Public for the State of New York  
In presence of \_\_\_\_\_  
\_\_\_\_\_

## 4670 CERTIFICATE OF DEATH

Reg. Dist. No.

04744

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring.</b> c. LENGTH OF STAY IN 1b <b>27</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2310 Kansas Ave.,</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring.</b> d. STREET ADDRESS <b>2310 Kansas Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>C.</b> Last <b>REDDIX</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>11</b> Year <b>19 60</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2, 1873</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Daniel Green</b>				14. MOTHER'S MAIDEN NAME <b>Maria Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT <b>Ruth Walker</b> Address <b>2310 Kansas Ave., Silver Spring, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO <b>Chronic Myo Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myo Carcinoma</b> (c) <b>Chronic Myo Carcinoma</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs (P)</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)	
21. I certify that I attended the deceased from <b>March 1, 1960</b> , to <b>April 11, 1960</b> , that I last saw the deceased alive on <b>4-11</b> , 19 <b>60</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Calvin B. McCarty</b>		M.D. <b>61 P St N E</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>4/11/60</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<b>Burial</b>	<b>4/14/60</b>	<b>Mt. Zion,</b>		<b>Mt. Zion, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Sunde</b>		ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

422.2

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH - 4721

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>DC.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN <u>5 mo.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>		d. STREET ADDRESS <u>514 Crittendon St., NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ralph</u> First <u>Rhodes</u> Middle <u>Rhodes</u> Last		4. DATE OF DEATH <u>Apr 16</u> 19 <u>60</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-20-1885</u> 75 yrs.	
9. AGE (In years last birthday) <u>75</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Ralph Rhodes</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Garganellus</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO (b) <u>Cardiac Insufficiency</u> DUE TO (c) <u>Cardiac Insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>6 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>4-16-60</u>			
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22c. DATE THEREOF <u>APRIL 19 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL</u>		22d. LOCATION (City, town, or country) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR <u>Real Funeral Home, Wash., D.C.</u>				24a. REC'D BY REGISTRAR <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kram</u>	

MEDICAL CERTIFICATION

FOR STATE  
RECORD FILE

(M)

(I)

(S)

(C)

(D)

1891

1892

1893

1894

1895

1896

1897

1898

1899

1900

1901

1902

1903

1904

1905

1906

1907

1908

1909

1910

1911

1912

1913

1914

1915

1916

1917

1918

1919

1920

1921

1922

1923

1924

1925

1926

1927

1928

1929

1930

1931

1932

1933

1934

1935

1936

1937

1938

1939

1940

1941

1942

1943

1944

1945

1946

1947

1948

1949

1950

1951

1952

1953

1954

1955

1956

1957

1958

1959

1960

1961

1962

1963

1964

1965

1966

1967

1968

1969

1970

1971

1972

1973

1974

1975

1976

1977

1978

1979

1980

1981

1982

1983

1984

1985

1986

1987

1988

1989

1990

1991

1992

1993

1994

1995

1996

1997

1998

1999

2000

2001

2002

2003

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014

2015

2016

2017

2018

2019

2020

2021

2022

2023

2024

2025

2026

2027

2028

2029

2030

2031

2032

2033

2034

2035

2036

2037

2038

2039

2040

2041

2042

2043

2044

2045

2046

2047

2048

2049

2050

2051

2052

2053

2054

2055

2056

2057

2058

2059

2060

2061

2062

2063

2064

2065

2066

2067

2068

2069

2070

2071

2072

2073

2074

2075

2076

2077

2078

2079

2080

2081

2082

2083

2084

2085

2086

2087

2088

2089

2090

2091

2092

2093

2094

2095

2096

2097

2098

2099

2100

2101

2102

2103

2104

2105

2106

2107

2108

2109

2110

2111

2112

2113

2114

2115

2116

2117

2118

2119

2120

2121

2122

2123

2124

2125

2126

2127

2128

2129

2130

2131

2132

2133

2134

2135

2136

2137

2138

2139

2140

2141

2142

2143

2144

2145

2146

2147

2148

2149

2150

2151

2152

2153

2154

2155

2156

2157

2158

2159

2160

2161

2162

2163

2164

2165

2166

2167

2168

2169

2170

2171

2172

2173

2174

2175

2176

2177

2178

2179

2180

2181

2182

2183

2184

2185

2186

2187

2188

2189

2190

2191

2192

2193

2194

2195

2196

2197

2198

2199

2200

2201

2202

2203

2204

2205

2206

2207

2208

2209

2210

2211

2212

2213

2214

2215

2216

2217

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

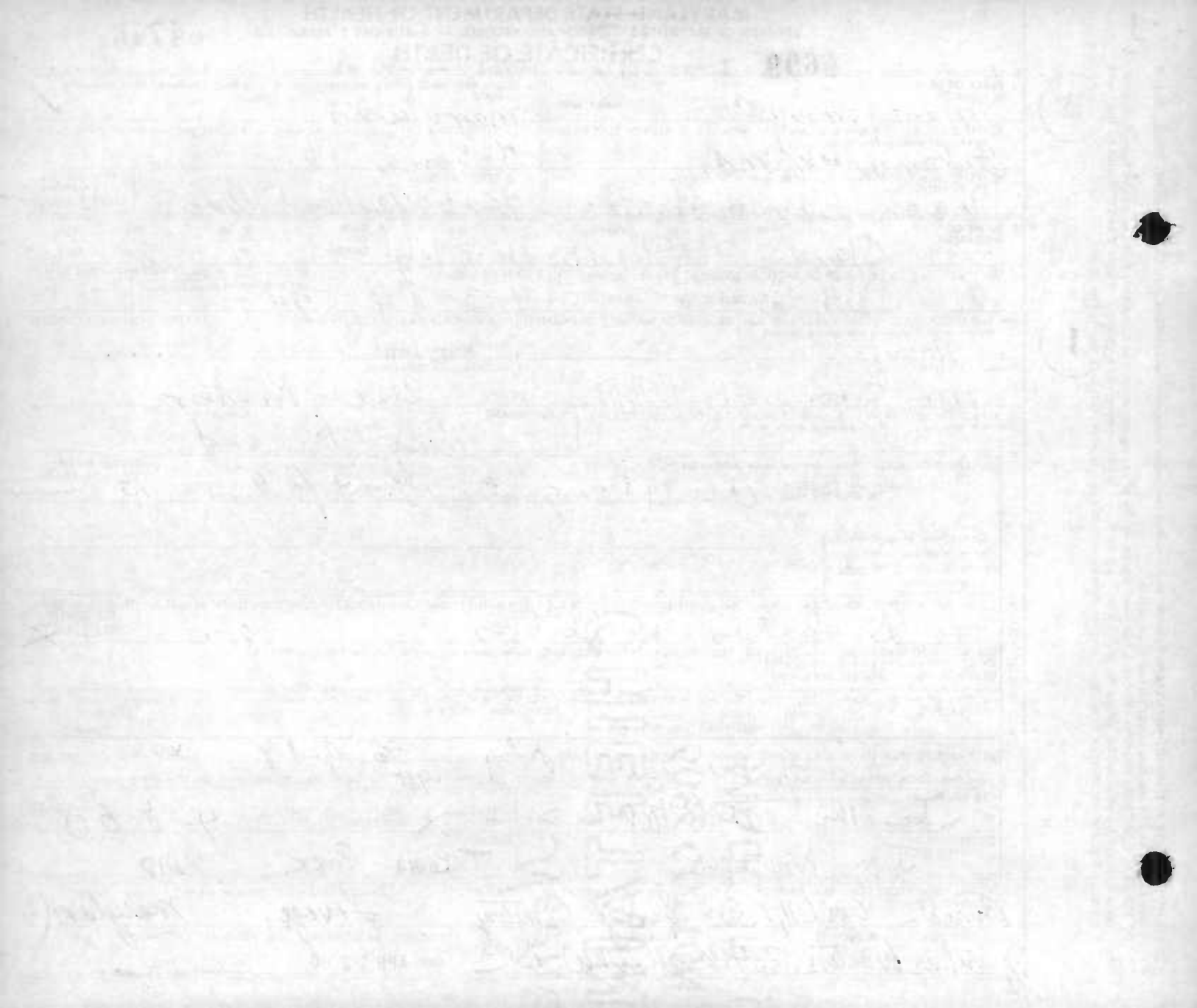
4699

Items 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

04746

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Pk Md</u>		c. LENGTH OF STAY IN 1b <u>1654</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Gen. Hosp.</u>		d. STREET ADDRESS <u>7225 Garland Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>Elizabeth</u> Last <u>Riley</u>		4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-3-86</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W.S.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. Samuel Woltz</u>		14. MOTHER'S MAIDEN NAME <u>Clara Krater</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Hoop. Record</u>	
17. INFORMANT Address <u>Hoop. Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>10 yrs.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1956</u> to <u>April 8 1960</u> , that (I) (we) last saw the deceased alive on <u>April 7 1960</u> and that death occurred at <u>7:14 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James H. Whitlock</u>		22b. DATE SIGNED <u>4-8-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>J.N. WHITLOCK</u>		22d. ADDRESS <u>TAKOMA PARK MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 11, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Savage, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		25a. REC'D BY REGISTRAR DATE <u>APR 12 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Carlton S. Evans</u>			





4810

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery.</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia.</b> b. COUNTY <b>Arlington.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown, Md.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington, Virginia.</b>		
c. LENGTH OF STAY IN 1b <b>4 Mo.</b>			d. STREET ADDRESS <b>3015 N. Edison St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Marylander Sanitarium.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Fitzhugh</b> Last <b>Robbins.</b>			4. DATE OF DEATH Month <b>April</b> Day <b>26th.</b> Year <b>19 60</b>		
5. SEX <b>Female.</b>	6. COLOR OR RACE <b>White.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15th. 1887.</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>12</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt.</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>James S. Fitzhugh. (Dec.)</b>			14. MOTHER'S MAIDEN NAME <b>Louisa Page. (Dec.)</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None.</b>	17. INFORMANT <b>Mrs John F. Burns.</b> Address <b>3015 N. Edison St, Arl. Va.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO <b>Acute nephritis, pyelo.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO <b></b> (c) <b></b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>5 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>Dec. 10, 1959</b> to <b>April 28, 1960</b> , that I last saw the deceased alive on <b>4/27</b> , 19 <b>60</b> , and that death occurred at <b></b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>James P. Kerr</b>		ADDRESS (Street, city or town, state) <b>Damascus, Md.</b>		DATE SIGNED <b>4/28/60</b>	
PHYSICIAN'S NAME (Type) <b>James P. Kerr.</b> <b>Damascus, Maryland.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial.</b>	22b. DATE THEREOF <b>4/30/60.</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens Cemetery.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph F. Biech. SONS 3034 Mt. View</b>		ADDRESS <b>WASH. D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 2 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be obtained by the hospital or attending physician.

# CERTIFICATE OF DEATH

1910

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>NAME OF DECEASED                  John W. Wilson</p>		<p>AGE                  60</p>		<p>SEX                  Male</p>		<p>RACE                  White</p>		<p>DATE OF DEATH                  April 1, 1910</p>		<p>PLACE OF DEATH                  Baltimore, Maryland</p>	
<p>RESIDENCE                  Baltimore, Maryland</p>		<p>CAUSE OF DEATH                  Heart Disease</p>		<p>IMMEDIATE CAUSE                  Coronary Thrombosis</p>		<p>INTERMEDIATE CAUSE                  Atherosclerosis</p>		<p>PRE-EXISTING DISEASES                  Hypertension</p>		<p>DATE OF BIRTH                  April 1, 1850</p>	
<p>DATE OF DEATH                  April 1, 1910</p>		<p>PLACE OF DEATH                  Baltimore, Maryland</p>		<p>CAUSE OF DEATH                  Heart Disease</p>		<p>IMMEDIATE CAUSE                  Coronary Thrombosis</p>		<p>INTERMEDIATE CAUSE                  Atherosclerosis</p>		<p>PRE-EXISTING DISEASES                  Hypertension</p>	
<p>DATE OF BIRTH                  April 1, 1850</p>		<p>PLACE OF BIRTH                  Baltimore, Maryland</p>		<p>CAUSE OF BIRTH                  Normal</p>		<p>IMMEDIATE CAUSE                  Normal</p>		<p>INTERMEDIATE CAUSE                  Normal</p>		<p>PRE-EXISTING DISEASES                  None</p>	
<p>DATE OF DEATH                  April 1, 1910</p>		<p>PLACE OF DEATH                  Baltimore, Maryland</p>		<p>CAUSE OF DEATH                  Heart Disease</p>		<p>IMMEDIATE CAUSE                  Coronary Thrombosis</p>		<p>INTERMEDIATE CAUSE                  Atherosclerosis</p>		<p>PRE-EXISTING DISEASES                  Hypertension</p>	

## CERTIFICATE OF DEATH

Reg. Dist. No.

4671

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2220 WASHINGTON AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CARRIE</b> Middle <b>C</b> Last <b>ROBINSON</b>		4. DATE OF DEATH Month <b>4</b> - Day <b>5</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/1/1872</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac J. Chase</b>		14. MOTHER'S MAIDEN NAME <b>Xarifa D. Chase</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Olive Robinson</b>		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO <b>Atherosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senility, Generalized Atherosclerosis</b> DUE TO (c) <b>Senility, Generalized Atherosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 4, 1960</b> to <b>April 5, 1960</b> , that I last saw the deceased alive on <b>April 4, 1960</b> , and that death occurred at <b>4:20 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bernard H. Fitzgerald</b> M.D.		ADDRESS (Street, city or town, state) <b>217 University Blvd E</b> DATE SIGNED <b>4-5-60</b>	
PHYSICIAN'S NAME (Type) <b>BERNARD H. FITZGERALD</b>		<b>Silver Spring Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	22b. DATE THEREOF <b>4/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>2901 North St. N.W.</b> <b>Washington 9, D.C.</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>

TO HOST OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4811

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> <b>47X-3</b>			
c. LENGTH OF STAY IN 1b <b>17 days</b>				d. STREET ADDRESS <b>36 Florida Avenue, N.E.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clarice</b> Middle <b>(None)</b> Last <b>Rogers</b>				4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>December 12, 1914</b>		9. AGE (In years lost birthday) <b>45</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unascertainable</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lonnie Williams</b>				14. MOTHER'S MAIDEN NAME <b>Nora Berry</b>			
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>578-20-5458</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Cervix with Metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>3 Years</b> <b>4 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 25</b> , 1960, to <b>April 11</b> , 1960, that I last saw the deceased alive on <b>April 11</b> , 1960, and that death occurred at <b>1:45 a.m.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Alan B. Retik</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>4-11-60</b>			
PHYSICIAN'S NAME (Type) <b>ALAN B. RETIK, M.D.</b>				National Institutes of Health <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/15/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John P. Stewart</b>				ADDRESS <b>30 H Street, N.E.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 13 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1717

1911

Division of

Washington

IT

Division

The Division of

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4700

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>33 Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>13222 Turkey Br. Park</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>David Gerald Rubin</u>		4. DATE OF DEATH Month Day Year <u>4-21-60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-57</u>
9. AGE (In years last birthday) <u>3</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Philip Rubin</u>		14. MOTHER'S MAIDEN NAME <u>Sandra Richman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mother</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock due to hemorrhage, urinary bladder</u> DUE TO (b) <u>Pelvic &amp; abdominal retroperitoneal hemorrhage</u> DUE TO (c) <u>Laceration of perineal floor</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs 15 min</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>—</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by truck while backing out of driveway</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>9:45 P.m. 4-21-1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) (County) (State) <u>Rockville Monty Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Bluschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BLUSCHART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-22-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY &amp; SONS - 3501-14th St NW</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>APR 25 '60</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
Item 6 Film G261 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 04751

<p>1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b></p> <p>c. LENGTH OF STAY IN b. <b>55</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6204 Kennedy Br.</b></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>e. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b></p> <p>d. STREET ADDRESS <b>6204 Kennedy Drive</b></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Davis Rush</b></p> <p>4. DATE OF DEATH Month Day Year <b>Apr. 14 19 60</b></p>		<p>5. SEX <b>female</b></p> <p>6. COLOR OR RACE <b>Negro</b></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>8. DATE OF BIRTH <b>5/23/1892</b></p> <p>9. AGE (In years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b></p> <p>10b. KIND OF BUSINESS OR INDUSTRY</p> <p>11. BIRTHPLACE (State or foreign country) <b>N.C.</b></p> <p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>		<p>13. FATHER'S NAME <b>John Davis</b></p> <p>14. MOTHER'S MAIDEN NAME <b>Julia Kirk</b></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</p> <p>16. SOCIAL SECURITY NO.</p> <p>17. INFORMANT Address</p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <b>Coronary occlusion</b> (c)</p>		<p>INTERVAL BETWEEN ONSET AND DEATH <b>Found dead on floor</b></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>Previously treated at a Wash. Clinic for myocardial infarct</b></p>		<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>		<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b></p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>			
<p>ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.</p> <p>EXAMINER'S NAME (Type) <b>Frank J. Broschart</b></p>		<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p> <p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p> <p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>DATE SIGNED <b>Apr. 17, 1960</b></p> <p>Address (Street, city, town, or county)</p>	
<p>22a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b></p> <p>22b. DATE THEREOF <b>4/18/60</b></p> <p>22c. NAME OF CEMETERY OR CREMATORY <b>Carver Memorial,</b></p> <p>22d. LOCATION (City, town, or country) (State) <b>Muirkirk, Md.</b></p>		<p>23. FUNERAL DIRECTOR <b>Robert L. Swarden</b> ADDRESS <b>Rockville, Md.</b></p> <p>24a. REC'D BY REGISTRAR <b>APR 19 '60</b></p> <p>24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b></p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

48.1

+

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

4813

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04752

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd</b>		c. LENGTH OF STAY IN 16 <b>X Boyd</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>No Street address</b>		d. STREET ADDRESS <b>No Street address</b>	
3. NAME OF DECEASED (Type or print) <b>Lloyd Edward Sanbower</b>		4. DATE OF DEATH <b>April 26, 1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 19, 1920</b>
9. AGE (In years last birthday) <b>39</b>		10. IF UNDER 1 YEAR <b>7</b> Months <b>7</b> Days <b>7</b> Hours <b>7</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done in regular or seasonal employment) <b>Signal Maintainer laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Montie J. Sanbower</b>		14. MOTHER'S MAIDEN NAME <b>Grace Shry</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. II 218-12-7654</b>	
17. INFORMANT <b>Montie J. Sanbower (father)</b>		Address <b>Item 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONTUSIONS AND LACERATIONS OF BRAIN STEM</b> DUE TO <b>816X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b) AUTOMOBILE ACCIDENT</b> DUE TO <b>(c)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>SUDDEN</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>PASSANGER IN TRUCK WHICH WAS STRUCK BY CAR</b>	
20c. TIME OF INJURY Month, Day, Year <b>4:45 p.m. 4/26/60</b>		20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> <b>Not While at work</b> <input checked="" type="checkbox"/> <b>highway</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Boyd</b>		20f. (City or town) <b>Montg. Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DATE THEREOF <b>4-29-60</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>		Address (Street, city, town, or county) <b>4/27/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		24a. REC'D BY REGISTRAR <b>APR 28 '60</b>	
ADDRESS <b>Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



1

4213

NO STREET ADDRESS

NO STREET ADDRESS

APRIL 20, 1960

LIFE INSURANCE COMPANY

SEPT. 12, 1960

WHITE

STANDARD INSURANCE CO. 1000000000

MA.

WHITE

W.M. II 218-2-7054

WHITE

ADDITIONAL ADDRESS

PASSENGER IN TRUCK WHICH WAS STRUCK BY CAR

4-20-60

WHITE

WHITE

WHITE

WHITE

WHITE

4-20-60

ADDITIONAL ADDRESS

ADDITIONAL ADDRESS

ROBERT A. WILSON

ADDITIONAL ADDRESS

ADDITIONAL ADDRESS

## CERTIFICATE OF DEATH

Reg. Dist. No. 4753

4722

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kemsington Gardens</b>		d. STREET ADDRESS <b>1608 Evarts St N.E.</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNE</b> Middle Last <b>SANDERS</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>1960</b>	
5. SEX <b>Fe</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 21, 1876</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frank Posey</b>		14. MOTHER'S MAIDEN NAME <b>Laura F Gray</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b> INFORMANT <b>Margaret A Sanders</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE HEART FAILURE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>GENERAL ARTERIOSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>2 years</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>3/18</b> , 19 <b>60</b> , to <b>4/26</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4/26</b> , 19 <b>60</b> , and that death occurred at <b>2:55</b> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John E. Everett</b> M.D. <b>9400 CONN. AVE</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>JOHN E. EVERETT M.D. KENSINGTON, MD.</b>			
22a. BURIAL, CREMATION, or other disposition (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>4-29-60</b>	<b>Glenwood</b>	<b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home Washington D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 28 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

D.O.B.

Montgomery

Washington

Washington

1933

Washington

Washington

Washington

Dec. 21, 1933

Dec. 21, 1933

Washington D.C.

none

George F. Gray

Frank Ross

none - Frank Ross & George F. Gray

no

George F. Gray

Frank Ross

George F. Gray

Frank Ross

George F. Gray

Frank Ross

George F. Gray

Frank Ross

George F. Gray

Frank Ross

George F. Gray

Frank Ross

George F. Gray

Frank Ross

George F. Gray

Frank Ross

George F. Gray

Frank Ross

George F. Gray

Frank Ross

George F. Gray

Frank Ross

Washington D.C.

4-22-30 - Glenwood

Butler

See General Report - Washington D.C.

4814  
CERTIFICATE OF DEATH

Reg. Dist. No.

1155

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>Box # 528</b>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>(None)</b> Last <b>Sasek</b>				4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 14, 1917</b>	
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mining</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Matthew Sasek</b>				14. MOTHER'S MAIDEN NAME <b>Dora Berich</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>210-03-2952</b>			
INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Operative Death: mitral stenosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Mitral insufficiency and mitral stenosis</b> DUE TO (c) <b>Inactive rheumatic heart disease</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>years</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 3</b> , 19 <b>60</b> to <b>April 13</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 13</b> , 19 <b>60</b> , and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>4/14/60</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE <b>Robert D. Bloodwell</b>				M.D. <b>Robert D. Bloodwell, M.D.</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Removal</b>		<b>4/14/60</b>		<b>Wash</b>		<b>South Fork, Penna</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. 2901-14th St NW D.C.</b>				24a. RECEIVED BY REGISTRAR DATE <b>APR 18 60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

410X

CERTIFICATE OF DEATH

1914

Deceased

Name

Residence

Health

Age

Sex

Date

Time

Place

Cause

Manner

Signature

Witness

Info

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Info

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Info

Signature

Signature

Signature

Signature

Signature

Signature

Signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

Deputy Medical Examiner, Montgomery Co., notified

MONTGOMERY STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
4815 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital					d. STREET ADDRESS 65 M Street, N.W.						
3. NAME OF DECEASED (Type or print) First Middle Last Karen Denise SAUNDERS			4. DATE OF DEATH Month Day Year April 26 1960								
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-17-59		9. AGE (In years lost birthday) yrs. 4		IF UNDER 1 YEAR Months Days Hours Min. 4 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Raymond B. SAUNDERS					14. MOTHER'S MAIDEN NAME Althea Laverne LANCASTER						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viremia, type undetermined 096.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from DOA 19 to DOA 19, that (I) (we) last saw the deceased alive on DOA 19, and that death occurred at 5P M, from the causes and on the date stated above.											
22a. SIGNATURE H. L. Walton					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 4-27-60				
22c. PHYSICIAN'S NAME (Type) H. L. WALTON, LT, MC, USN					22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 2, 1960		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City, town, or county) (State) Arlington Virginia				
24. FUNERAL DIRECTOR'S SIGNATURE W. B. Jarvis Funeral Home, 1432 U St., NW, WashDC					25a. REC'D BY REGISTRAR DATE APR 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines				

2051781XV4



CERTIFICATE OF DEATH

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

4816

## CERTIFICATE OF DEATH

04757

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>22 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Co. Gen. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Katherine</b> Middle <b>H.</b> Last <b>Schmidt</b>				4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 14, 1877</b>	
9. AGE (In years lost birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>William Heuman</b>				14. MOTHER'S MAIDEN NAME <b>Mary Henzie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Robert J. Schmidt, Damascus, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident, Hemiplegia ft. 2 days</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Arteriosclerosis generalized</b> ?? DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial asthma</b> <b>Arteriosclerotic ulcers feet with gangrene; arthritis;</b> Blind cause unknown 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Main Street</b>				20g. (County) <b>Damascus</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>9/28/59</b> , 19____, to <b>4/9/60</b> , 19____, that I last saw the deceased alive on <b>4/9/60</b> , 19____, and that death occurred at <b>2:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Main Street, Damascus, Md.</b> DATE SIGNED <b>4/11/60</b>							
ACTUAL SIGNATURE <b>Gilbert F. Meadors</b>				M.D. <b>Gilbert F. Meadors, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Gilbert F. Meadors, M.D.</b>				Damascus, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/12/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Damascus Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Damascus, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. Molsworth</b>				ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 13 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

331X

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

4723

04758

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>DC</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>6 days</u>				d. STREET ADDRESS <u>3201 Wisconsin Ave. N.W. Apt. 80</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanatorium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u>				4. DATE OF DEATH <u>Apr 19 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-29-62</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Mln.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Mo.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>Phillip Schnellbacher</u>				14. MOTHER'S MAIDEN NAME <u>Unobtainable</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>			
17. INFORMANT <u>Kensington Garden Sec. Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Confluent Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>2 days</u> DUE TO (c) <u>Interval between onset and death</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell from chair in Sanatorium</u>			
20c. TIME OF INJURY Month, Day, Year <u>Apr 4-16 1960</u> Hour a.m. <u>1:00</u> p.m. <u>2:00</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sanatorium</u>				20f. (City or town) <u>Kensington</u> (County) <u>Montgomery</u> (State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>4-20-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>4/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Evangelical</u>		22d. LOCATION (City, town, or country) (State) <u>St. Louis, Missouri</u>	
23. FUNERAL DIRECTOR <u>The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>APR 21 '60</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

STATE OF ALABAMA  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE  
OF ALABAMA



MISSISSIPPI

NAME



TO

DATE

THE STATE OF ALABAMA  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Signature of Medical Examiner

THE STATE OF ALABAMA  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO DECEASED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

4672 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4759

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9305 Worth Avenue</u>				1d. STREET ADDRESS <u>9305 Worth Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maurice</u> Middle <u>David</u> Last <u>SEILIN</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-28-86</u>	
9. AGE (in years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Intelligence Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Siberia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>David SEILIN</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Gotlieb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Armed</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Washington Sanitarium + Hospital</u> <u>Hospital chart from recent hospitalization</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>subleth</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>4-20-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/25/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4701  
CERTIFICATE OF DEATH

04760

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>5 1/2 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 15</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>0975 Washington San. &amp; Hosp.</u>				d. STREET ADDRESS <u>2716 Colesville-Bellville Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>N.M.N.</u> Last <u>Sheets</u>				4. DATE OF DEATH Month <u>4</u> Day <u>14</u> Year <u>1960</u>					
5. SEX <u>fe</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-20-03</u>			
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Binder Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Haynes Lithograph Co.</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>John Valko</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Formndje</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>unknown</u>		17. INFORMANT <u>Pt's Hospital Record</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus, mild</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u> <u>1 month</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>December 1959</u> to <u>April 14</u> 1960, that (I) (we) last saw the deceased alive on <u>April 14</u> 1960, and that death occurred at <u>6:30</u> PM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Bennet A. Porter, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 15, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr.</u>				22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 18, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARK'S CHURCH CEMETERY FAIRLAND, MARYLAND</u>		23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 19 60</u>			
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1911

10

11

12

13

14

15

4673

## CERTIFICATE OF DEATH

Reg. Dist. No.

64761

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>29 SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9312 HARVEY ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>H.</u> Last <u>SHORES</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 1882</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANUFACTURER WOOLLEN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LITHUANIA</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILFRED SHORES</u>		14. MOTHER'S MAIDEN NAME <u>LEAH SIRKIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>HAROLD SURREY</u>		Address <u>9312 HARVEY ROAD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GEN. ARTERIOSCLEROSIS</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>APRIL 3, 1960</u> , to <u>APRIL 29, 1960</u> , that I last saw the deceased alive on <u>APRIL 28, 1960</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>JACK J. RHEINGOLD</u> M.D.		ADDRESS (Street, city or town, state) <u>1302-18th St NW</u> DATE SIGNED <u>4/29/60</u>	
PHYSICIAN'S NAME (Type) <u>JACK J. RHEINGOLD</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
22b. DATE THEREOF <u>MAY 1-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM PARK FALLS CHURCH, VA</u>	
22d. LOCATION (City, town, or county) (State) <u>  </u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Hume</u> ADDRESS <u>4217-9th St NW</u>	
24a. REC'D BY REGISTRAR <u>  </u> DATE <u>MAY 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4674 CERTIFICATE OF DEATH

64762

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 2 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X SILVER SPRING		d. STREET ADDRESS 1224 TANLEY ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1224 TANLEY ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last IONE UTTERBACK SHORTZ		4. DATE OF DEATH Month Day Year APRIL 17 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/75
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD UTTERBACK		14. MOTHER'S MAIDEN NAME ANNA NELSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Joseph E. Blomgren, 1224 Tanley Rd.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH —	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 18 1959, to Apr. 17 1960, that (I) (we) last saw the deceased alive on Apr. 15 1960, and that death occurred at 9A.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas J. Kelly		22b. DATE 4/17/60	
22c. PHYSICIAN'S NAME (Type) THOMAS J. KELLY		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		23b. DATE THEREOF 4/20/60	
23c. NAME OF CEMETERY OR CREMATORY GRACELAND CEMETERY		23d. LOCATION (City, town, or county) (State) VALPARISO, INDIANA	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Phipps, INC.		25a. REC'D BY REGISTRAR DATE APR 19 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	



002X

1

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### 4817 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>			c. LENGTH OF STAY IN 1b <b>8 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Derwood</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County Gen.</b>				d. STREET ADDRESS <b>Route # 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Shumaker</b>				4. DATE OF DEATH Month <b>April</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 10, 1960</b>		9. AGE (In years last birthday) yrs. <b>11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Infant</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Samuel Shumaker</b>				14. MOTHER'S MAIDEN NAME <b>Helen Estelle Coleman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TRANSPOSITION OF THE AORTA</b> <b>754.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4-10-60</b>		20f. (City or town) (County) (State) <b>4-10-60</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4-10-60</b> to <b>12:55 P</b> , that (I) (we) last saw the deceased alive on <b>4-10-60</b> , and that death occurred at <b>12:55 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Jack Schumacher</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/10/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Jack Schumacher, M.D.</b>				22d. ADDRESS <b>26 N. Summit Ave., Gaithersburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/12/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>APR 12 '60</b>	
						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Knepp</i>	

2073399XV7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1217 - COUNCIL OF DEATH



MADE IN U.S.A.

FOR SALE

4818

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

64765

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montg.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban Hospital</b>		d. STREET ADDRESS <b>4708 Bradley Blvd.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Howard Elmer Skipper Jr.</b>		4. DATE OF DEATH Month Day Year <b>April 9, 1960 19</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/2/1892</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Instrument maker</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Howard E. Skipper</b>		14. MOTHER'S MAIDEN NAME <b>Annie (Unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Howard L. Skipper Chevy Chase, Md - son</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertention</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.V. About four years ago.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		DATE SIGNED <b>April 9, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/12/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 12 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanes</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [REDACTED]  
AGE: [REDACTED]  
SEX: [REDACTED]  
RACE: [REDACTED]  
DATE OF BIRTH: [REDACTED]  
PLACE OF BIRTH: [REDACTED]  
DATE OF DEATH: [REDACTED]  
PLACE OF DEATH: [REDACTED]  
CAUSE OF DEATH: [REDACTED]  
MANNER OF DEATH: [REDACTED]  
SIGNATURE OF EXAMINER: [REDACTED]  
DATE: [REDACTED]

4-21-7

1  
FOR STATE  
HEALTH DEPT.  
M  
X  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
4675 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04766

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8904 Glenville Rd</u>				d. STREET ADDRESS <u>8904 Glenville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sean Harmon Smith</u>				4. DATE OF DEATH Month Day Year <u>Apr. 16 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-9-1960</u>	
9. AGE (In years last birthday) yrs. <u>2</u> Months <u>7</u> Days <u>7</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Rolt Donald Smith</u>				14. MOTHER'S MAIDEN NAME <u>Hilda P. Harmon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>R. J. Smith -</u>		Address <u>Stuen 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>suppur. Prop. Infection</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschek</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHEK</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>4-16-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 19, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL. CEM.</u>		22d. LOCATION (City, town, or country) (State) <u>ARLINGTON VA</u>	
23. FUNERAL DIRECTOR <u>H. Don. DeVOL</u>				ADDRESS <u>WASH. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	
24a. REC'D BY REGISTRAR <u>2224-Wis Ave NW</u>				DATE <u>APR 18 '60</u>			



475 X



4819

## CERTIFICATE OF DEATH

Reg. Dist. No.

04767

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodfield</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 1, Gaithersburg, Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Snowden</u>		4. DATE OF DEATH <u>April - 18 - 1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March - 23 - 1894</u>
9. AGE (in years lost birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House - buying</u>	
11. BIRTHPLACE (State or foreign country) <u>Barnesville, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Edward Hamilton</u>		14. MOTHER'S MAIDEN NAME <u>Mary Emma Bruce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mary S. Hamilton, B-1, Gaithersburg, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute heart failure</u> 544.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Indigestion</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1/2 to 1 hr</u> <u>30 hours</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April - 17 - 1960</u> , to <u>April - 16 - 1960</u> , that I last saw the deceased alive on <u>April - 18 - 1960</u> , and that death occurred at <u>10:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Miller</u>		M.D. <u>7 - Barnes Ave., Gaithersburg, Md</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM C. MILLER</u>		ADDRESS <u>Gaithersburg, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/22/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Barnesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. H. H.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



4820

CERTIFICATE OF DEATH

04768

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>Rt. #3</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sadie</b>			First <b>E</b> Middle <b>Snowden</b> Last			4. DATE OF DEATH Month <b>4</b> Day <b>20</b> Year <b>19 60</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/20/90</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Hall</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>?</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>BLAINE H. EIG.</b>				M.D. _____			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/23/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Emory Grove Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Gaithersburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 26 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

178K

CERTIFICATE

1880

11

POSTAGE

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

1-14

4676 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> a. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>3 weeks</u>		d. STREET ADDRESS <u>301-Torrington Crescent</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>301-Torrington Crescent</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edna Vivian Spradlin</u>		4. DATE OF DEATH Month Day Year <u>April 8<sup>th</sup> 19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 18, 1885</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Braddock, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles B. Chroniger</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Johnstone</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350X</u> DUE TO <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>Parkinsonism</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoarthritis, generalized</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 19 60</u> to <u>April 8 19 60</u> , that I last saw the deceased alive on <u>April 7 19 60</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u> M.D.		ADDRESS (Street, city or town, state) <u>217 University Blvd E</u> DATE SIGNED <u>4-8-60</u>	
PHYSICIAN'S NAME (Type) <u>Bernard A. Fitzgerald</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-11-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home Inc.</u>		ADDRESS <u>Mt. Rainier, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/5B



3507

CERTIFICATE OF DEATH

1958

4702

## CERTIFICATE OF DEATH

Reg. Dist. No.

04770

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. Hyattsville</u>		<u>1651.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium &amp; Hospital</u>				d. STREET ADDRESS <u>5031-36th Pl.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maria</u> Middle <u>(N)</u> Last <u>Steiner</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5, 1981</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph - Reiger</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Kern</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Address <u>Pt's. Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIO SCLEROTIC HEART Dis.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTRACAPSULAR FRACT. OF NECK OF R. FEMUR</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FALL DOWN STAIRS</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>8:15</u> <u>3</u> <u>25</u> <u>1960</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HOME</u>		20f. (City or town) (County) (State) <u>HYATTSVILLE PR. GEO. MD</u>	
21. I certify that I attended the deceased from <u>3/25</u> , 19 <u>60</u> , to <u>4/4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/4/60</u> , 19 <u>60</u> , and that death occurred at <u>3:45 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Oliver</u>				M.D. <u>1108 WOODSIDE HWY</u>		DATE SIGNED <u>4/4/60</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN OLIVER</u>				<u>SILVER SPRING MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u>				ADDRESS <u>4812 Ga Ave NW DC</u>		24a. REC'D BY REGISTRAR DATE <u>APR 11 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1964</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN AND A REGISTRAR OF THE MARYLAND STATE DEPARTMENT OF HEALTH. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON. IT IS NOT VALID IF SIGNED BY A PHYSICIAN WHO IS NOT A MEMBER OF THE MARYLAND MEDICAL ASSOCIATION. IT IS NOT VALID IF SIGNED BY A REGISTRAR WHO IS NOT A MEMBER OF THE MARYLAND STATE DEPARTMENT OF HEALTH. IT IS NOT VALID IF SIGNED BY A PHYSICIAN WHO IS NOT A MEMBER OF THE MARYLAND MEDICAL ASSOCIATION. IT IS NOT VALID IF SIGNED BY A REGISTRAR WHO IS NOT A MEMBER OF THE MARYLAND STATE DEPARTMENT OF HEALTH.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

4821

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>Virginia</b> COUNTY <b>Arlington</b> <b>Fairfax</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>	c. LENGTH OF STAY IN 1b <b>4 hours</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Falls Church</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>2433 Holmes Run Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Jan</b> Middle <b>Frederick</b> Last <b>STOKES</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-13-35</b>
9. AGE (In years last birthday) <b>24</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Air Force</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Carl F. STOKES</b>	
14. MOTHER'S MAIDEN NAME <b>Sylvia LARSON</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>1955-1959</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Official Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pyelonephritis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>3rd degree burns (40 % of body)</b> DUE TO (c) <b>6 wks</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was lighting charcoal fire with gasoline (gas exploded)</b>	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>February 201960</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Falls Church Fairfax Va.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-6-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>
22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>		22e. REC'D BY REGISTRAR DATE <b>APR 5 '60</b>	
22f. REGISTRAR'S SIGNATURE <b>Arthur S. H...</b>		22g. REGISTRAR'S SIGNATURE	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b>		ADDRESS <b>3072 M St. NW, Washington, D.C.</b>	



4677 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Utica Thurmont-- rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home of son 1620 Parham Rd</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Effie</b> Middle <b>Irane</b> Last <b>Stottlemeyer</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-20-1876</b>
9. AGE (In years last birthday) <b>84 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Harper</b>		14. MOTHER'S MAIDEN NAME <b>Phoebe Craver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Franklin Stottlemeyer</b>		Address <b>1620 Parham Rd. Silver Spring, Md.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease and</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Macrocytic anemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b> <b>10 yrs.</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Curricular flutter</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1955</b> to <b>April 21, 1960</b> , that I last saw the deceased alive on <b>April 20, 1960</b> , and that death occurred at <b>11:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Samuel M. Bageant M.D.</b>		DATE SIGNED <b>4/21/60</b>	
PHYSICIAN'S NAME (Type) <b>SAMUEL M. BAGEANT</b>		<b>WASHINGTON, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-24-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Utica Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Utica Fred. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Bageant</b>		ADDRESS <b>Thurmont, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4822

CERTIFICATE OF DEATH

64773

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington DC.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>		d. STREET ADDRESS <u>Apt. 103 1760 Euclid St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>M.</u> Last <u>Sweeney</u>		4. DATE OF DEATH Month <u>April</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fraternal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
13. FATHER'S NAME <u>James H. Boswell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-18-5712</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 23</u> , 19 <u>60</u> , to <u>April 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 25</u> , 19 <u>60</u> , and that death occurred at <u>7:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stuart L. Nelson</u>		DATE SIGNED <u>4/25/60</u>	
PHYSICIAN'S NAME (Type) <u>Stuart L. Nelson</u>		ADDRESS (Street, city or town, state) <u>7425 Aspen Court T.P. Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/28/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>APR 27 '60</u>	
ADDRESS <u>2901-14th St. N.W. Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



11



1852

1  
M  
4678

4774

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

4678 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>11,010 CONE LANE</b>		d. STREET ADDRESS <b>11,101 CONE LANE</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>THOMAS</b> Last <b>TAFF</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>17</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 1, 1898</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Policeman (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Police Dept.</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD TAFF</b>		14. MOTHER'S MAIDEN NAME <b>LUVENE GAINES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>579-50-1937</b>	
17. INFORMANT <b>Mrs. Gladys H. Taff, 11,010 Cone Lane Silver Spring, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis, coronary</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 21, 1960</b> to <b>April 17, 1960</b> , that (I) (we) last saw the deceased alive on <b>March 26, 1960</b> , and that death occurred at <b>12:20 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>A. W. Smith</b>		22b. DATE SIGNED <b>4/17/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. W. SMITH</b>		22d. ADDRESS <b>13018 GEORGIA AVE SILVER SPRING, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>4/20/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Prince Geo. County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Zucka</b>		25a. REC'D BY REGISTRAR <b>APR 19 60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hanna</b>		25c. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Broschant notified and approved.

an Smith M.D.

4-20-1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH e. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <i>md</i> b. COUNTY <i>montg</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>36 Wheaton</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>11610 Gail Place</i>		d. STREET ADDRESS <i>11610 Gail Place</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Ora May Tew</i>		4. DATE OF DEATH Month Day Year <i>April 13 1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-1-97</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.C.</i>	
13. FATHER'S NAME <i>Jerry Matthews</i>		14. MOTHER'S MAIDEN NAME <i>Janie Buckner</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <i>Sylvester Tew (husband)</i>	
17. INFORMANT <i>Ther</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute congestive heart failure</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>hypertension</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>3 yrs</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>FRANK J. Broschart</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/15/1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		22d. LOCATION (City, town, or country) (State) <i>Rockville, Maryland</i>	
23. FUNERAL DIRECTOR <i>Nalley's Funeral Home Inc.</i>		24. REC'D BY REGISTRAR <i>APR 18 '60</i>	
ADDRESS <i>Mt. Rainier Md</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanks</i>	



IN WITNESS WHEREOF  
I have hereunto set my hand and  
affixed the official seal of the  
Department of Health, at  
Washington, D. C., this 1st day of  
April, 1918.

44

1

State of New York  
County of New York  
City of New York  
I, the undersigned, Medical Examiner, do hereby certify that  
the within and foregoing is a true and correct copy of the  
original as the same appears from the records of the  
Department of Health, at Washington, D. C., this 1st day of  
April, 1918.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 4732 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04776

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>DE.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>2 days</u>				d. STREET ADDRESS <u>5425 Conn. Ave. N.W. Apt 216</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rockville Plaza motel</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Howard Thomas</u>				4. DATE OF DEATH <u>Apr 17 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-1-1895</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Claims Investigator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Vet adm.</u>		11. BIRTHPLACE (State or foreign country) <u>DE.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Wm Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Mary McDonald</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>YES WORLD WAR I</u>				17. INFORMANT <u>Ellen Thomas (wife)</u> Address <u>Stem 2</u>			
16. SOCIAL SECURITY NO. <u>578-10-9696</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1) Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Coronary artery sclerosis</u> (c) <u>?</u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>4-17-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>APR 21 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington hall</u>		22d. LOCATION (City, town, or country) <u>Arlington Va</u> (State) _____	
23. FUNERAL DIRECTOR <u>Wm Walton</u> ADDRESS <u>3603 14th St NW</u>				24a. REC'D BY REGISTRAR <u>APR 19 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1943

1943



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4824

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Barnesville</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HATTIE</b> Middle <b>TIBBS</b> Last <b>TIBBS</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>13</b> Year <b>1960</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 9, 1899</b>	
9. AGE (In years lost birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Moses Tibbs</b>				14. MOTHER'S MAIDEN NAME <b>Christine Simms</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
INFORMANT <b>Charles R. Tibbs</b>				Address <b>Barnesville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO <b>600.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO <b>Pyelonephritis</b> (c) <b>Diabetes mellitus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>3 weeks</b> <b>3 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>2 Oct 1948</b> , to <b>13 April 1960</b> , that I last saw the deceased alive on <b>11 April 1960</b> , and that death occurred at <b>10:17 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John G. Fawcett</b>				M.D. <b>Dorsonville</b>			
PHYSICIAN'S NAME (Type) <b>JOHN G. FAWCETT M.D.</b>				ADDRESS (Street, city or town, state) <b>P.O. Boyds Rd</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>4/16/60</b>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion,</b>	
22d. LOCATION (City, town, or county) (State) <b>Barnesville, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Swanson</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 19 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Farris</b>							

6920

1

## CERTIFICATE OF DEATH

Reg. Dist. No.

4703

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 hrs.-5 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>075 Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>3100 Powder Mill Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>Everard</u> Middle <u>-</u> Last <u>Todd</u>				4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-27-90</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Everard Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Hagill Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral occlusion &amp; shock ad hypotension</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>6-8 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/2</u> to <u>5/3</u> , 19 <u>60</u> that I last saw the deceased alive on <u>4/21</u> , 19 <u>60</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas H Wolohin</u>				DATE SIGNED <u>4/3/60</u>			
PHYSICIAN'S NAME (Type) <u>Chas H Wolohin</u>				M.D. <u>7600 Cawell Ave</u> <u>Hydrom Park, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-7-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawley's sons</u> ADDRESS <u>1756 B Ave. N.W. Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





4704

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

047779

1. PLACE OF DEATH o. COUNTY <u>MONT GOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>VA.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. LENGTH OF STAY IN 1b <u>67</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>83X-3</u> <u>ARLINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM &amp; Hospital.</u>				d. STREET ADDRESS <u>4412 N. 4th Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Cook Tompkins</u>				4. DATE OF DEATH Month Day Year <u>April 24 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-25-80</u>	
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>UNDERWEAR</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>BEVERLY R. Tompkins</u>				14. MOTHER'S MAIDEN NAME <u>Sallie Thompson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>PT's chart</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.2</u> DUE TO <u>Pneumonia - Viral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive Cardiac Failure</u> DUE TO (c) <u>3 months</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>March 1 1960</u> to <u>April 24 1960</u> , that (I) (we) last saw the deceased alive on <u>April 24 1960</u> , and that death occurred at <u>5:50</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert A. Hare</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/24/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>				22d. ADDRESS <u>809 Davis Ave, Takoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 28, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edna J. Hare</u> ADDRESS <u>2847 Wilson Blvd. Arlington, Va.</u>				25a. REGISTRY REGISTRATION DATE <u>APR 29 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Edna J. Hare</u>	

CERTIFICATE OF DEATH

4708

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4679  
CERTIFICATE OF DEATH

64780

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>2½ yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>21 Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9839 Cherry Tree Lane</b>				d. STREET ADDRESS <b>1 9839 Cherry Tree Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ROSE LILLIAN TOWNSEND</b>				4. DATE OF DEATH Month Day Year <b>April 1, 1960 19</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 21, 1878</b>	
9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Theodore Stradley</b>				14. MOTHER'S MAIDEN NAME <b>Gertrude Clugston</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John Townsend, 9839 Cherry Tree Lane, Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary insufficiency</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease with</b> DUE TO <b>Aortic stenosis</b> (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>Known</b> <b>3 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>October 25, 1957</b> , to <b>April 1, 1960</b> , that (I) (we) last saw the deceased alive on <b>March 27, 1960</b> , and that death occurred at <b>8:00 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Aaron H. Traum</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED <b>April 1, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Aaron H. Traum</b>				22d. ADDRESS <b>B237 Georgia Ave Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 5 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mingo Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mingo, Washington County, Pa.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond C. Zisk</b>				ADDRESS <b>Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 4 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

• 2008

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
WT. 1 lb. 4825 CERTIFICATE OF DEATH 64781 Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>45 Bethesda</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					1. STREET ADDRESS <u>6007 Beech Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Basy</u> Middle <u>Boy</u> Last <u>TREXLER</u>					4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1960</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>April 17, 1960</u>		9. AGE (In years last birthday) yrs. <u>2</u> Min. <u>47</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN PETER TREXLER</u>					14. MOTHER'S MAIDEN NAME <u>VIRGINIA RUTH HAMILTON</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>FATHER</u>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prenatally</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Interstitial Pregnancy</u> DUE TO <u>E Rupture &amp; Haemorrhage</u> (c) <u>—</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>4/17</u> , 19 <u>60</u> , to <u>4/17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>4/17</u> , 19 <u>60</u> , and that death occurred at <u>5:25</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4430 Montain - Bethesda</u> DATE SIGNED <u>—</u>									
ACTUAL SIGNATURE <u>D Franklin Hodges MD</u>					PHYSICIAN'S NAME (Type) <u>D FRANKLIN HODGES MD</u> <u>BETHESDA MD</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>			22b. DATE THEREOF <u>4-17-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Suburban hospital</u>			22d. LOCATION (City, town, or county) (State) <u>8600 Old Georgetown Rd Bethesda MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital</u> ADDRESS <u>8600 Old Georgetown Rd Bethesda MD</u>					24a. REC'D BY REGISTRAR DATE <u>APR 21 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Beth - MD</u>		

2074312XV Bethesda MD





4826

## CERTIFICATE OF DEATH

64782

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>New Market</b> 10X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>None</b>			
3. NAME OF DECEASED (Type or print) First <b>Maurice</b> Middle <b>Franklin</b> Last <b>Trittipoe</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-15-14</b>		9. AGE (In years lost birthday) <b>45</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hauling</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William M. Trittipoe</b>				14. MOTHER'S MAIDEN NAME <b>Nora M. Titus</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. II</b>		16. SOCIAL SECURITY NO. <b>218-24-7593</b>		INFORMANT <b>Carrie Trittipoe</b>		Address <b>New Market, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, left anteroseptal</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>Thrombosis, ant. descending br., left coronary art.</b> DUE TO (c) <b>2 day</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 day</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 14, 1960</b> , to <b>April 16, 1960</b> , that I last saw the deceased alive on <b>April 15, 1960</b> , and that death occurred at <b>7:20 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. Bowditch Hunter, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>809 Veins Mill Rd.</b> DATE SIGNED <b>4/16/60</b>			
PHYSICIAN'S NAME (Type) <b>G. Bowditch Hunter, Jr.</b>				Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/19/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Leesburg, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son; Frederick, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>APR 19 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.1

1

1  
B  
M  
073  
I

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4827  
CERTIFICATE OF DEATH

64784

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>VICTOR -- VALLIANT</b>				4. DATE OF DEATH Month Day Year <b>APRIL 30 19 60</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/24/71</b>		9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>JAMES VALLIANT</b>			14. MOTHER'S MAIDEN NAME <b>MARTHA THOMPSON</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>332X</b> DUE TO <b>Myoplegia the sublethia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebrological arteriosclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>20 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/31</b> 19 <b>60</b> to <b>4/30</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>4/30</b> 19 <b>60</b> , and that death occurred at <b>2:15</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>A. D. Bonifant</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M. D.</b>				22d. ADDRESS <b>SANDY SPRING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Burial May 4, 1960</b>		<b>May 4, 1960</b>		<b>Spring Hill Cemetery</b>		<b>Easton, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hampton Harrison</b>				ADDRESS <b>St. Michaels Md</b>		25a. REC'D BY REGISTRAR <b>DATE MAY 5 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Clifton L. Kenna</b>			

# CERTIFICATE OF DEATH

1883

1883

DECEASED

AGE

SEX

DATE

TIME

PLACE

CAUSE

MANNER

PLACE

TESTIFY

TESTIFY

TESTIFY

TESTIFY

TESTIFY

TESTIFY

CERTIFICATE

1883

1883

1883

## CERTIFICATE OF DEATH

Reg. Dist. No.

64785

4724

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Rest Home</b>				e. STREET ADDRESS <b>4956 Battery Lane</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ara</b> Middle <b>L.</b> Last <b>VANDERCOOK</b>				4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 19, 1868</b>		9. AGE (In years lost birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months <b>5</b> Days <b>2</b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Census Bureau</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired-U.S. Govt</b>		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>Grand-son</b> Address <b>J. D. Libbey, 10908 N. H. Ave. Silver Spring, Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage, Massive</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalised</b> DUE TO (c) <b>10 yrs +</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatism, chronic, benign</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>1950</b> to <b>April 21</b> , 1960 that I last saw the deceased alive on <b>April 21</b> , 1960, and that death occurred at <b>8:55 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stewart Clapp</b>				DATE SIGNED <b>4.22.60</b>			
PHYSICIAN'S NAME (Type) <b>Stewart Clapp</b>				M.D. <b>3921 Ingomar St NW Wash. 15 D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>4/25/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>APR 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10

1

Robert J. Murphy-Bethesda, Maryland

Creation 11/25/1960 Cedar Hill, Maryland

Bethesda

Maryland

No Name

J. D. Libbey, 10903 R. E. Ave. Silver Spring, Md.

Unknown

Unknown

Central Bureau

Registered-U.S. Govt. Michigan

USA

Male White

Nov. 10, 1938

3 1

L. VANDERBROOK

Kenneth G. Gorman East House

4355 Battery Lane

Bethesda

Bethesda

Montgomery

Maryland

Montgomery

CERTIFICATE OF DATA

4828

## CERTIFICATE OF DEATH

64786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <b>Canada</b> b. COUNTY <b>Quebec</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Comte de Beauce</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>St. Martin (Boduc)</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Pauline (None) Veilleux</b>				4. DATE OF DEATH Month Day Year <b>April 6 1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 3, 1926</b>		9. AGE (In years lost birthday) <b>33</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Unascertainable</b>		11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>
13. FATHER'S NAME <b>Emery Poulin</b>				14. MOTHER'S MAIDEN NAME <b>Angeline Maheux</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO <b>195.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adrenal cortical carcinoma</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>5 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 24, 1960</b> , to <b>April 6, 1960</b> , that I last saw the deceased alive on <b>April 6, 1960</b> , and that death occurred at <b>8:20 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>4/6/60</b>							
ACTUAL SIGNATURE <b>Howard S. Schwartz</b>		M.D. <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>Howard S. Schwartz, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Martin Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St. Martin Beauce Co., Quebec</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Prob 37

Casey

4787

4829

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>			
c. LENGTH OF STAY IN 1b <b>25 days</b>				d. STREET ADDRESS <b>10810 Kenilworth Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Judith Maurine Walker</b>				4. DATE OF DEATH Month Day Year <b>April 15 1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 16, 1947</b>		9. AGE (In years last birthday) <b>12 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Arizona</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Jack H. Walker</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Nash</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fungal infection in lungs</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute leukemia</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute appendicitis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 21</b> , 19 <b>60</b> , to <b>April 15</b> , 19 <b>60</b> that I last saw the deceased alive on <b>April 15</b> , 19 <b>60</b> and that death occurred at <b>10:35 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Lawrence A. Gaydos</b> M.D. <b>The Clinical Center</b> <b>4/16/60</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/20/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 19 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knap</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/58

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C. Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> WASHINGTON 47X3	
c. LENGTH OF STAY IN 1b <u>6 months</u>		d. STREET ADDRESS <u>5609 Colorado Ave., NW</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>130 Lynmoor Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>BURTON</u> Last <u>Ware</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-maker (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Krusen</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Burton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT Address <u>Silver Spring, Md.</u>		17. NAME OF INFORMANT <u>Richard Ware</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>3 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1</u> , 19 <u>60</u> , to <u>April 13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 13</u> , 19 <u>60</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond Bradshaw, Jr.</u>		DATE SIGNED <u>4/13/60</u>	
PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw, Jr.</u>		ADDRESS (Street, city or town, state) <u>345 University Blvd, West Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/16/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

u4788

4680



4221

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Damascus</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Damascus</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9514 Pleasant Plains Rd.</b>		d. STREET ADDRESS <b>9514 Pleasant Plains Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b>S.</b> Last <b>Watkins</b>		4. DATE OF DEATH Month <b>April</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16, 1882</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Damascus, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Levi W. Pearce</b>	
14. MOTHER'S MAIDEN NAME <b>Marian Jones</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>--</b>		INFORMANT <b>Miss Marian Watkins, Damascus, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure due to Arteriosclerotic Heart Disease Cardio-vascular-renal Disease.</b> DUE TO (b) <b>2 yrs.</b> DUE TO (c) <b>10 yrs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1935</b> , 19____, to <b>4/23/60</b> , 19____, that I last saw the deceased alive on <b>April 23, 1960</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. McKendree Boyer, M.D.</b>		ADDRESS (Street, city or town, state) <b>9830 Main Street, Damascus, Md</b>	
PHYSICIAN'S NAME (Type) <b>M. McKendree Boyer, M.D.</b>		DATE SIGNED <b>4/25/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/26/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Damascus Meth/</b>	22d. LOCATION (City, town, or county) (State) <b>Damascus, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Mohaworth</b>		24a. REC'D BY REGISTRAR DATE <b>APR 28 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DECLASSIFICATION GUIDE

1980



1. The following information is being released to you for your information only. It is not to be used for any other purpose.

2. This information is being released to you under the provisions of the Freedom of Information Act, 5 U.S.C. 552.

3. The information is being released to you in accordance with the following schedule:

4. The information is being released to you in accordance with the following schedule:

5. The information is being released to you in accordance with the following schedule:

6. The information is being released to you in accordance with the following schedule:

7. The information is being released to you in accordance with the following schedule:

8. The information is being released to you in accordance with the following schedule:

9. The information is being released to you in accordance with the following schedule:

10. The information is being released to you in accordance with the following schedule:



11. The information is being released to you in accordance with the following schedule:

12. The information is being released to you in accordance with the following schedule:

13. The information is being released to you in accordance with the following schedule:

14. The information is being released to you in accordance with the following schedule:

15. The information is being released to you in accordance with the following schedule:

16. The information is being released to you in accordance with the following schedule:

17. The information is being released to you in accordance with the following schedule:

18. The information is being released to you in accordance with the following schedule:

19. The information is being released to you in accordance with the following schedule:

20. The information is being released to you in accordance with the following schedule:

21. The information is being released to you in accordance with the following schedule:

22. The information is being released to you in accordance with the following schedule:

23. The information is being released to you in accordance with the following schedule:

24. The information is being released to you in accordance with the following schedule:

25. The information is being released to you in accordance with the following schedule:

26. The information is being released to you in accordance with the following schedule:

27. The information is being released to you in accordance with the following schedule:

28. The information is being released to you in accordance with the following schedule:

29. The information is being released to you in accordance with the following schedule:

30. The information is being released to you in accordance with the following schedule:



31. The information is being released to you in accordance with the following schedule:

32. The information is being released to you in accordance with the following schedule:

33. The information is being released to you in accordance with the following schedule:

34. The information is being released to you in accordance with the following schedule:

35. The information is being released to you in accordance with the following schedule:

36. The information is being released to you in accordance with the following schedule:

37. The information is being released to you in accordance with the following schedule:

38. The information is being released to you in accordance with the following schedule:

39. The information is being released to you in accordance with the following schedule:

40. The information is being released to you in accordance with the following schedule:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—HEALTH-MORE, 18

Item 1 Film 261 4-18-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

64790

4705

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>P.G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private Home</u>		d. STREET ADDRESS <u>903 Jackson Ave</u>	
3. NAME OF DECEASED (Type or print) <u>William E. Hatts</u>		4. DATE OF DEATH <u>April 7</u> 19 <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-11-1885</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Eng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steam Fitting</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard Hatts</u>		14. MOTHER'S MAIDEN NAME <u>Alice Crawford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Mary E. Hatts</u>	
17. INFORMANT <u>wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Pulmonary edema</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>est. 6-10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> 19 <u>60</u> , to <u>April</u> 19 <u>60</u> , that I last saw the deceased alive on <u>April 7</u> 19 <u>60</u> , and that death occurred at <u>12:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph P. Patten</u> M.D.		ADDRESS (Street, city or town, state) <u>8641 Lakeside Road</u>	
PHYSICIAN'S NAME (Type) <u>DALPH F. PATTEN</u>		DATE SIGNED <u>4/7/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-9-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. ...</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. ...</u>	

CERTIFICATE OF DEATH

2708

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male	
3. AGE 65		4. DATE OF BIRTH 1883	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Carpenter	
7. MARITAL STATUS <input checked="" type="checkbox"/> Married		8. DATE OF MARRIAGE 1915	
9. NAME OF SPOUSE Mary H. Harris		10. DATE OF DEATH 1948	
11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY Hypertension, Atherosclerosis		14. PRESENT ILLNESS Myocardial Infarction	
15. PHYSICIAN'S SIGNATURE Dr. J. H. Smith		16. PLACE OF INTERMENT Catholic Cemetery	
17. NAME OF FUNERAL HOME John Doe & Co.		18. SIGNATURE OF REGISTRAR John Doe	
19. DATE OF REGISTRATION 1948		20. OFFICIAL SEAL	

Vertical text on the right margin, likely a filing or archival stamp.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4706 Items 2, 3 & 8 Film 4263 5/26/60 iwr

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park

c. LENGTH OF STAY IN 1b DOA

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Maryland b. COUNTY Prince Georges

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 20. D.C.

d. STREET ADDRESS 716 1/2 Mason St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Lemuel Middle Siebert Last Weidman

4. DATE OF DEATH Month 4 Day 21 Year 1960

5. SEX m 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 7-18-02 9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Foreman 10b. KIND OF BUSINESS OR INDUSTRY Road Const 11. BIRTHPLACE (State or foreign country) West Virginia 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Calvin Weidman 14. MOTHER'S MAIDEN NAME Ida Kerns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address George Weidman - son

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Coronary occlusion  
420.1 DUE TO  
Conditions, if any, which gave rise to immediate cause (b) sudden  
(a), stating the underlying cause lost. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Frank J. Broschat M.D. CHIEF MEDICAL EXAMINER ☐ DATE SIGNED 4-21-60  
EXAMINER'S NAME (Type) FRANK J. Broschat ASSISTANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial April 23-60 22b. DATE THEREOF April 23-60 22c. NAME OF CEMETERY OR CREMATORY Acker Hill Cemetery 22d. LOCATION (City, town, or county) (State) Smithland Md

23. FUNERAL DIRECTOR'S SIGNATURE Sammons Bros ADDRESS 1661-9th Ave NE 24a. REC'D BY REGISTRAR DATE APR 22 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO DECEASED: This certificate should be executed within 24 hours after death. If any other certificate is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

706

THE EXAMINER

1. Name of deceased: *John Doe*

2. Date of death: *Jan 15, 1925*

3. Place of death: *Home*

4. Age: *45*

5. Sex: *Male*

6. Race: *White*

7. Occupation: *Teacher*

8. Cause of death: *Heart disease*

9. Manner of death: *Natural*

10. Signature of examiner: *John Doe*

11. Signature of physician: *John Doe*

12. Signature of coroner: *John Doe*

13. Signature of registrar: *John Doe*

14. Signature of undertaker: *John Doe*

15. Signature of funeral home: *John Doe*

16. Signature of cemetery: *John Doe*

17. Signature of church: *John Doe*

18. Signature of school: *John Doe*

19. Signature of hospital: *John Doe*

20. Signature of other: *John Doe*

21. Signature of other: *John Doe*

22. Signature of other: *John Doe*

23. Signature of other: *John Doe*

24. Signature of other: *John Doe*

25. Signature of other: *John Doe*

26. Signature of other: *John Doe*

27. Signature of other: *John Doe*

28. Signature of other: *John Doe*

29. Signature of other: *John Doe*

30. Signature of other: *John Doe*

31. Signature of other: *John Doe*

32. Signature of other: *John Doe*

33. Signature of other: *John Doe*

34. Signature of other: *John Doe*

REMARKS

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO BE FILLED IN BY THE EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)  
15M 9/59

1  
B  
M  
X  
I  
0  
1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
4733 CERTIFICATE OF DEATH

64792

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>10</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>709 Brent Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>709 Brent Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Fannie</b> Middle <b>S.</b> Last <b>WENNER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Montg. Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin Shouffer</b>		14. MOTHER'S MAIDEN NAME <b>Martina Sheid</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Niece</b> Address <b>Marie A. Long H 702 Maple Ave. Rockville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-6-60</b> 19 to <b>2-6-60</b> 19, that (I) (we) last saw the deceased alive on <b>2-6-60</b> 19, and that death occurred at <b>2:45</b> PM, from the causes and on the date stated above.			
22a. SIGNATURE <b>William Frank, M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM FRANK, M.D.</b>		22d. ADDRESS <b>544 W. MONTGOMERY ROCKVILLE, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr. 9, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Rockville Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey - Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>APR 11 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>			

2733

CERTIFICATE OF DEATH

Montgomery

Maryland

Montgomery

Rockville

Rockville

100 Franklin Road

100 Bryan Road

Female

Female

White

White

May 25, 1984

Housewife

Monty Co. Maryland

Benjamin Shouler

Married

None

None

No

Married A. born N 101 Maple Ave. Rockville, Md.

14

April 2, 1985

Rockville Cemetery

Rockville

Maryland

Robert A. Montgomery - Bethesda, Maryland



CERTIFICATE OF DEATH

1913

1913

1

1913

1913

1913

1913

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Items 18-21 Film 261 4-22-60 ams											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 04784											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>			c. LENGTH OF STAY IN 1b <u>80A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Silver Spring</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Saint Hosp.</u>					d. STREET ADDRESS <u>1610 Eldred st</u>						
3. NAME OF DECEASED (Type or print) <u>Lawrence Arley Winters</u>					4. DATE OF DEATH Month <u>Apr</u> Day <u>8</u> Year <u>1960</u>						
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-19-22</u>		9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>auto</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Luther C. Winters</u>					14. MOTHER'S MAIDEN NAME <u>Josephine Rhodes</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W. War II</u>				16. SOCIAL SECURITY NO. <u>232-26-2587</u>		17. INFORMANT <u>Anna Winters (wife)</u> Address <u>Stim 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon-Monoxide poisoning</u> <u>892.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>892.9</u> DUE TO (c) <u>892.9</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ethel alcohol 1.12 %</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>--</u>		20f. (City or town) <u>--</u> (County) <u>--</u> (State) <u>--</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Frank J. Broschart</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>4-8-60</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>4/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NORTH GLADE CEMETERY</u>			22d. LOCATION (City, town, or county) (State) <u>SWANTON, MARYLAND</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond B. Ziskar</u>					ADDRESS <u>SILVER SPRING, MD.</u>			24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Raymond B. Ziskar</u>	

APR 11 '60



MASSACHUSETTS DEPARTMENT OF HEALTH—BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1  
4709  
M  
075  
1  
0  
1

4709  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

64795

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>20 Takoma Park Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hosp.</u>				d. STREET ADDRESS <u>'8115 Chester St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Custer</u> Middle <u>Alex</u> Last <u>Wofford</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 12, 1889</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Civil Engineer.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>James A. Wofford.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Braden</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, and Cerebral Thrombosis</u> DUE TO (b) <u>Prostatic HyperTrophy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>8-10 days</u> <u>8-10 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malignant Hypertension.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 10, 1960</u> to <u>April 20, 1960</u> , that (I) (we) last saw the deceased alive on <u>April 20, 1960</u> , and that death occurred at <u>9:50 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Wilford D. Meyers</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wilford D. Meyers MD</u>				22d. ADDRESS <u>8823 Haddon Drive Takoma Park Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/22/60</u>		<u>George Washington Cemetery</u>		<u>Hyattsville Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. W. 25 Lande S. NW.</u>				25a. REC'D BY REGISTRAR <u>APR 25 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. W.</u>	

(11)

1

4831

## CERTIFICATE OF DEATH

64796

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>D. O. A.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				e. STREET ADDRESS <b>13005 Artie Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>Gordon</b> Last <b>Woodrum</b>				4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1918</b>	9. AGE (In years last birthday) <b>41</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Model Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt. Naval Research</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frederick Gordon Woodrum</b>				14. MOTHER'S MAIDEN NAME <b>Beatrice Anderson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W. W. II</b>		INFORMANT <b>Margaret Woodrum</b>		Address <b>13005 Artie Ave. Rockville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>53</b> , to <b>April</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4/24</b> , 19 <b>60</b> , and that death occurred at <b>7 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gregg P. Patten</b> M.D.				ADDRESS (Street, city or town, state) <b>8641-Colesville Road Silver Spring Md</b>		DATE SIGNED <b>4/24/60</b>	
PHYSICIAN'S NAME (Type) <b>RALPH F. PATTEN MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/26/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY - INC.</b> <b>Raymond A. Zilka</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 26 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1931

Decembris

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

1931

## 4832 CERTIFICATE OF DEATH

Reg. Dist. No. 4757

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Orange</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>47 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Samuel</b> Middle <b>Winborn</b> Last <b>Young</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 24, 1922</b>	9. AGE (In years lost birthday) <b>37</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Supply Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Airlines</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bernard A. Young</b>				14. MOTHER'S MAIDEN NAME <b>Stacy Phillips</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>246-14-9293</b>		INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive intra-abdominal hemorrhage</b> DUE TO 274X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Post-operative bilateral adrenalectomy</b> DUE TO (c) <b>Bilateral adrenal hyperplasia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>24 hours</b> <b>8 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>February 29, 1960</b> , to <b>April 16, 1960</b> , that I last saw the deceased alive on <b>April 16, 1960</b> , and that death occurred at <b>9:58A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 4/16/60</b> <b>The National Institutes of Health Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>Victor W. Sidel</b>		M.D. <b>The Clinical Center</b> <b>The National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>VICTOR W. SIDEL, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/19/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Stokesdale Meth Ch. Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Gilford Co. N. Carolina</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 19 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			



27/11

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

THE STATE OF NEW YORK, County of ...

IN SENATE, January 22, 1933

REPORT OF THE COMMISSIONER OF HEALTH

FOR THE YEAR 1932

ALBANY: J.B. LIPPINCOTT COMPANY, 1933

PRINTED BY THE STATE OF NEW YORK

AT ALBANY

January 22, 1933

1933

THE STATE OF NEW YORK  
DEPARTMENT OF HEALTH

REPORT OF THE COMMISSIONER OF HEALTH

1

M

4710

4798

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13. NAME OF DECEASED (Type or print) <u>Matilda Elizabeth Zager</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-23-95</u>	
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> Hours <u>1</u> Min. <u>0</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wisconsin</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>William Quade</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Hanning</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock - Hemorrhage</u> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rupture &amp; dissecting Aneurysm Arch Aorta</u> DUE TO <u>Atherosclerosis, Aorta</u> (c) <u>Myocardial infarction, old</u>							INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial infarction, old</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/8</u> 19 <u>60</u> , to <u>4/10</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>4/10</u> 19 <u>60</u> , and that death occurred at <u>3:30</u> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Marvin L. Tolkin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/10/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN L. TOLKIN</u>				22d. ADDRESS <u>8485 Fenton Street, SS, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/12/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>		23d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Mohsman</u>				ADDRESS <u>Damascus, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 13 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			

451X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4681

## CERTIFICATE OF DEATH

64799

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9703 Hedin Drive</u>		d. STREET ADDRESS <u>1347 Tewkesbury Place, N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>ZIMMERMAN</u> Last <u>ZIMMERMAN</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chaim Zimmerman</u>		14. MOTHER'S MAIDEN NAME <u>Chana —</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mrs. Mary Harris 1347 Tewkesbury Pl., N.W.</u>	
17. INFORMANT <u>Mrs. Mary Harris</u>		Address <u>1347 Tewkesbury Pl., N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Hemorrhage</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Hypertension Ht. Dis.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>15 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>49</u> , to <u>April 21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 21</u> , 19 <u>60</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>13000 Georgia Avenue, S.S., Md.</u> DATE SIGNED <u>4-21-60</u> ACTUAL SIGNATURE <u>S. L. Tabb, M.D.</u> M.D. PHYSICIAN'S NAME (Type) <u>S. L. Tabb, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-22-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. LEBANON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HYATTSVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY</u>		24a. REC'D BY REGISTRAR <u>APR 25 '60</u>	
ADDRESS <u>XSONS-3501-14 East NW</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

